2007 Healthy Families Program HEDIS Report

California Managed Risk Medical Insurance Board
Benefits and Quality Monitoring Division

November 2008

California Managed Risk Medical Insurance Board

Healthy Families Program (HFP)

MRMIB provides and promotes access to affordable coverage for comprehensive, high quality, cost effective health care services to improve the health of Californians.

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Introduction

The 2007 HEDIS Report for the Healthy Families Program (HFP) presents information on the quality of care provided by the 24 participating health plans. Each year, the health plans are required to report on a selection of quality measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[1]. HEDIS is a nationally recognized, standardized set of performance measures developed by the National Committee for Quality Assurance (NCQA®).

Monitoring health plan performance using HEDIS results is part of the Managed Risk Medical Insurance Board's (MRMIB) ongoing efforts to evaluate and improve the quality of care provided to the children enrolled in the program. Subscribers receive the results in enrollment materials, including the program handbook, and can use the information to compare health plan performance in key access and quality of care areas. The results are also published on the websites for MRMIB, HFP and the Office of the Patient Advocate (OPA).

Measures Selected for 2007

For 2007, each health plan submitted data to MRMIB for eleven HEDIS measures, including three new measures. The new measures are **bolded** below.

- *Childhood Immunization Status – Combination 2 and 3*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*
- *Adolescent Well Care Visits*
- *Children and Adolescents Access to Primary Care Practitioner*
- *Use of Appropriate Medications for People with Asthma*
- ***Appropriate Testing for Children with Pharyngitis***
- ***Appropriate Treatment for Children with Upper Respiratory Infections***
- ***Chlamydia Screening***
- *Mental Health Utilization*
- *Identification of Alcohol and Other Drug Services*

Summary of Overall Results

MRMIB has collected HEDIS data for the Healthy Families Program since 1999. Overall, the results show that rates continue to improve. The rates for 3 measures improved by at least 3 percentage points from 2006 and the rate for 4 measure remained the same or showed slight improvements.

Overall, the results indicate that HFP children are receiving the recommended services at a rate that is higher than most Medicaid plans and close to Commercial plans. The HFP weighted average for 7 of the 11 measures exceeded the national Medicaid average. The rates for 4 measures exceeded the national Commercial average.

One area of notable improvement is in *Adolescent Well-Care Visits*. While teens historically receive annual check-ups at very low rates, the HFP weighted average for this measure increased by 4 percentage points from 2006 and was an increase of 7 percentage points from 2005.

Another area of noticed improvement was in the number of children that received all of the recommended Combination 3 vaccinations. The HFP weighted average increased by 6% from 2006 and 23% from 2005. However, the percentage of children that received the Combination 2 vaccinations declined by 3% from the highest reported rate in 2005.

1 HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Summary of Overall Results (continued)

Analysis of the results by demographic variables revealed several interesting differences among ethnic groups and regions.

- Overall, Asian/Pacific Islander and African American children received the recommended services or appropriate treatment and testing at the highest rate while White children had the lowest rate.
- For the measures related to well-child visits, Asian/Pacific Islander , specifically Chinese language speakers, had the highest rate compared to White and English speakers who had the lowest rates.
- There were also significant differences in most of the measures when analyzed by region. The Bay Area region generally reported significantly higher rates compared to the Northern and Los Angeles regions which generally had the lowest rates. A map of the California regions and a list of the counties within each region is in Appendix A on page 71.
- There was no significant difference in the rates between groups based on household income.
- There were also no significant differences by gender, with the exception of *Well-Care Visits in the First 15 Months of Life* where males received all recommended visits at a higher rate and *Adolescent Well-Care Visits* where males over age 16 received a well-care visit at a significantly lower rate than females.

In 2007, MRMIB began collecting data for three new measures, *Appropriate Treatment for Children with Upper Respiratory Infections, Appropriate Testing for Pharyngitis and Chlamydia Screening*. The 2007 results indicate that there is an opportunity for future improvement in these measures. The HFP weighted average of all plans was below both the national Medicaid and Commercial averages.

High Performers

- Alameda Alliance had 7 rates that were above the national Commercial 90th percentile.
- Kaiser Permanente North had 6 rates that were above the national Commercial 90th percentile, even though they use the administrative data collection method.
- Two plans had rates that were above the national Commercial 90th percentile:
  - CalOptima Kids
  - San Francisco Health Plan

Low Performers

Three health plans had 7 rates that were below the national Commercial 10th percentile:

- Care 1st Health Plan
- Community Health Plan
- Health Plan of San Joaquin

Community Health Group had 6 rates that were below the national Commercial 10th percentile.

Conclusion

Overall, the 2007 HEDIS results reveal that children in the Healthy Families Program are receiving the recommended services and appropriate treatment. The rates for most measures continue to improve and most plans reported rates that are close to Commercial rates.

MRMIB is concerned about the low rates for the three new measures. Hopefully, as the plans continue to collect and report this data, the rates will improve.

MRMIB continues to be concerned about the low percentage of adolescents that receive well-care visits. However, it is heartening that there was an increase in rates over the last 3 years. When HEDIS results and the results of the Young Adult Health Care Survey (YAHCS) are considered together , it appears that a few plans are doing a better job of addressing the unique needs of their adolescent members compared to others. The following plans had significantly higher scores on many of the YAHCS ratings and had the highest rates for the *Adolescent Well-Care Visits* and *Children and Adolescents Access to Primary Care Practitioners, Ages 12 to 18 Years* measures:

- Alameda Alliance for Health
- CalOptima Kids
- Central Coast Alliance for Health
- Health Plan of San Mateo
- San Francisco Health Plan

Finally, there appear to be significant differences in the percentage of children that receive the recommended services among different ethnic groups and by region. This is an area for further research to determine if this is due to true disparities in the quality of care that is provided or if it is related to cultural factors, access or other issues.

The HFP plans will continue to report on the same HEDIS measures in 2008. A new measure, *Lead Screening*, will be reported for the 2008 measurement year and will be included in the 2008 HEDIS report.

NCQA gives specific guidelines for data collection and criteria such as eligible population, age group and continuous enrollment. Each health plan was responsible for collecting data based on the 2008 HEDIS technical specifications. MRMIB also requires all health plans to have their HEDIS data collection and reporting process certified by an NCQA certified auditor to ensure that the data is reliable and accurate.

Administrative and Hybrid Data Collection Methods

HEDIS data is collected through either administrative or hybrid data collection methods.

The administrative method requires plans to identify all eligible members and then search their administrative databases (e.g., enrollment, claims and encounter data systems) for evidence that a service was provided.

The hybrid method requires plans to select a random sample of eligible members and then search administrative databases and review medical records for evidence that services were provided.

HEDIS scores based on the hybrid method are generally higher than those based on the administrative method, but it is more costly and labor intensive to gather the data through the hybrid method than the administrative method.

It should also be noted that the following plans used the administrative method of data collections for some measures. This is an important consideration when comparing individual plan results.

- CenCal Health used the administrative method the *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* measure.
- Health Plan of San Joaquin used the administrative method for the *Well-Child Visits in the First 15 Months of Life* measure.
- Kaiser Permanente North and South used administrative data to report all HEDIS measures. However, Kaiser's performance, particularly on the new measures, is comparable, if not above, most of the HFP plans.
- Ventura County Health Care Plan used the administrative method to collect data for the *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* and *Adolescent Well-Care Visits* measures.

With the exception of data collected by the plans listed above, the following measures were collected using the hybrid method:

- *Childhood Immunization Status*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*
- *Adolescent Well-Care Visits*

The following measures were collected using the administrative method:

- *Children and Adolescents Access to Primary Care Practitioners*
- *Use of Appropriate Medications for Asthma*
- *Appropriate Treatment for Children with Upper Respiratory Infections*
- *Appropriate Testing for Children with Pharyngitis*

Administrative and Hybrid Data Collection Methods (continued)

- *Chlamydia Screening*
- *Mental Health Utilization*
- *Identification of Alcohol or Other Drug Services*

HFP Weighted Average

Throughout this report, the HFP overall program results are presented using a weighted average. This accounts for the large variance in plan enrollment and therefore, the eligible population for each measure. The use of a weighted average provides the most accurate estimate of the number of children that received each service. The weighted average was calculated using the rate and eligible population provided by the health plans for each measure.

Trends

Presented in the analysis for each measure is the HFP weighted average for the last 3 years. This comparison shows whether scores have improved or declined in the last 3 years.

Benchmarks

This report also provides comparisons of the HFP weighted average to several benchmarks, such as the state Medi-Cal Managed Care weighted average where available, the national Medicaid average and the national Commercial average for managed care plans.

The national Medicaid and Commercial averages are based on the most recent data available and uses the average rate of all plans that submitted data to NCQA for 2006 or 2007.

The rates reported by the HFP plans were generally higher than national Medicaid rates and were generally close to national Commercial rates. Since there is no comparison data to other State Children's Health Insurance Programs (SCHIP) for HEDIS, MRMIB has used the national Commercial 90th percentile to highlight the top performing plans. These plans reported rates that are among the highest in the country. The national Commercial 10th percentile was used to highlight the underperforming plans who have the greatest opportunity for improvement.

Demographic Analysis

In addition to the individual plan results, MRMIB has provided a demographic analysis for each measure. The results were compared across demographic variables such as spoken language, ethnicity, region, age group, gender and Federal Poverty Level (FPL). The rates presented in these charts reflect the percentage of each subgroup that received the recommended service. For example, for the *Childhood Immunization Status* measure, the results show that 86% of African American children received all recommended vaccinations. This represents the percentage of African American children who were included in the sample and who received the recommended vaccinations. While some of the sample sizes were smaller than others, all are included in the demographic analysis because it provides valuable information on opportunities for improving quality and access to care for certain populations. It also serves as a resource for future quality improvement activities.

The number of eligible members by measure and demographic variable is in Appendix B beginning on page 72.

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Childhood Immunization Status, Combination 2

Measure Definition

The ***Childhood Immunization Status, Combination 2*** measure assesses how many children under the age of 2 received the following recommended immunizations by their second birthday:

- Four diphtheria, tetanus and acellular pertusis (DTaP)
- At least three polio (IPV)
- At least one measles, mumps and rubella (MMR)
- Three H influenza type B (Hib)
- Three hepatitis B
- One chicken pox (VZV)

Why Is It Important?

This measure follows the Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations. [2] According to the Centers for Disease Control and Prevention (CDC), vaccines are among the most successful and cost-effective public health tools available for preventing disease and death. They not only help protect vaccinated individuals, but also help protect entire communities by preventing and reducing the spread of infectious diseases. Infants are particularly vulnerable to infectious diseases, which is why it is critical to protect them through immunizations. [3]

Overall Results

Seventy-nine percent (79%) of children under the age of two received all of the recommended Combination 2 vaccinations. These rates exceed the national Medicaid average and are essentially the same as the state Medi-Cal Managed Care weighted average. There was a slight increase in the Combination 2 rate from 2006, however, the rate is lower than 2005.

Benchmarking and Trend Analysis

Comparisons to state and national benchmarks for Combination 2 immunizations are presented in Figure 1. The HFP weighted average for Combination 2 immunizations for calendar years 2005 through 2007 are presented in Figure 2.

Figure 1. Comparison to State and National Benchmarks for Childhood Immunization Status - Combination 2

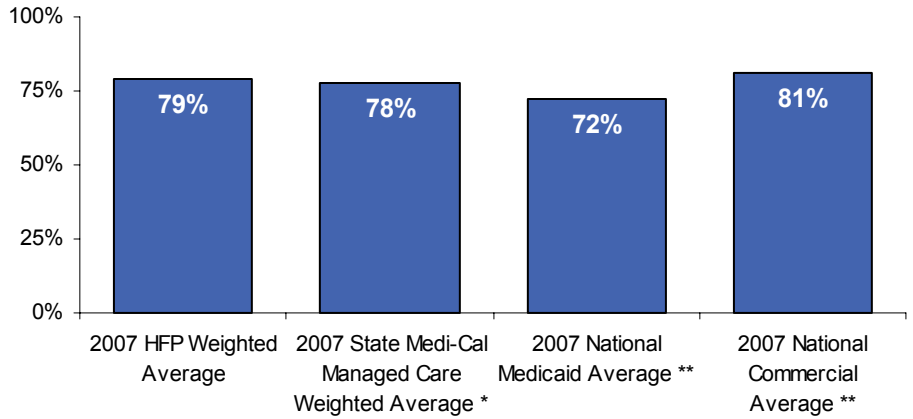
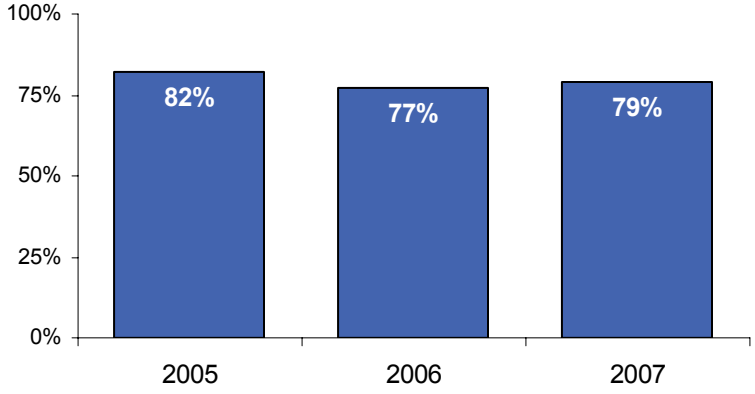


Figure 2. HFP 3 Year Trend for Childhood Immunization Status - Combination 2



2 ACIP guidelines for Immunizations are available at: http://www.cdc.gov/vaccines/recs/schedules/downlaods/child/2008

3 Centers for Disease Control and Prevention, http://www.cdc.gov

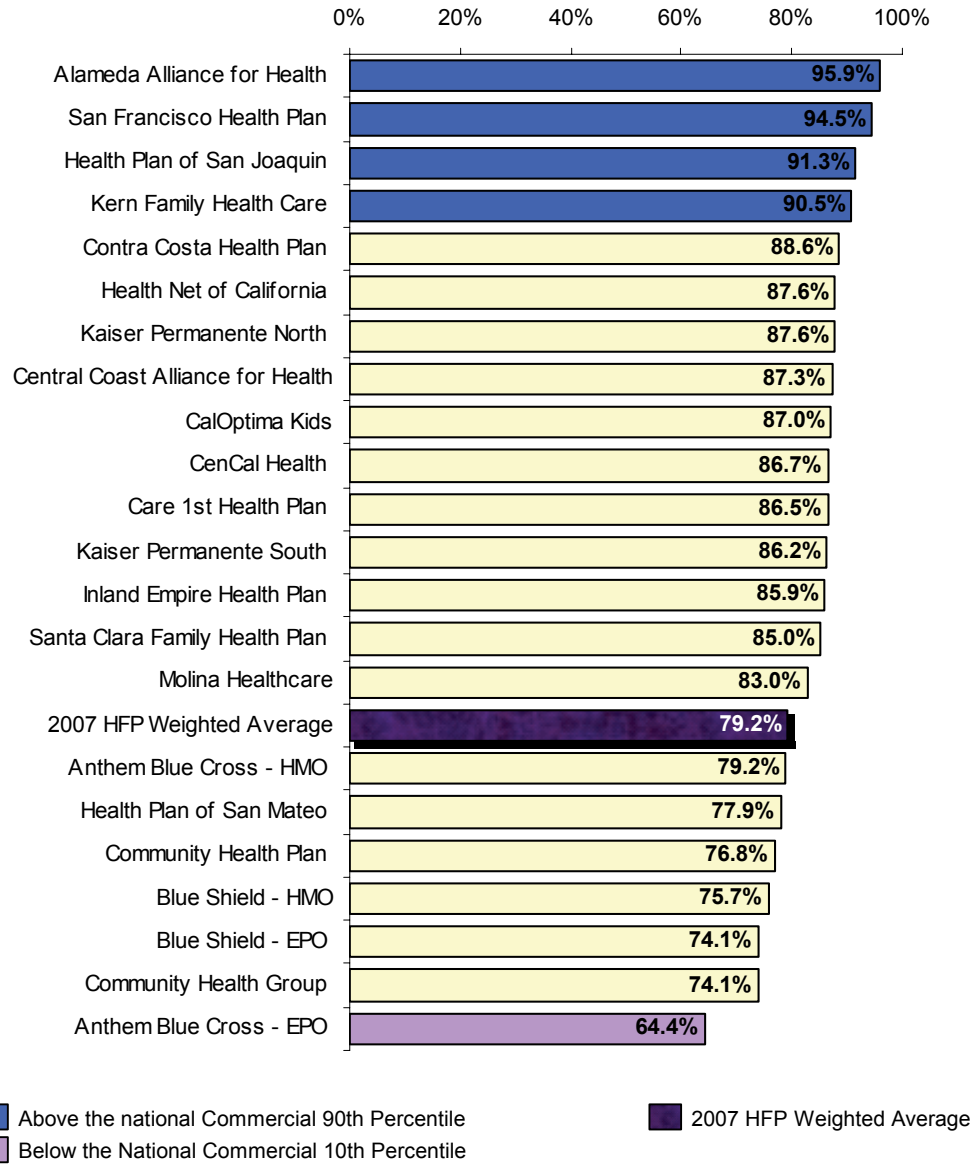
* Rate obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*

** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Childhood Immunization Status, Combination 2

The rates below represent the percentage of children under the age of 2 who received the recommended Combination 2 vaccinations.

Figure 3. Individual Plan Rates for Childhood Immunization Status - Combination 2



Health Plan Comparison

Individual plan rates ranged from 95.9% to 64.4%.

Four health plans had rates that were above the national Commercial 90th percentile (88.9%):

- Alameda Alliance for Health
- San Francisco Health Plan
- Health Plan of San Joaquin
- Kern Family Health Care

Anthem Blue Cross - EPO's rate was below the national Commercial 10th percentile (72.9%).

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Childhood Immunization Status, Combination 2

Figure 4. Childhood Immunization Status - Combination 2 by Spoken Language

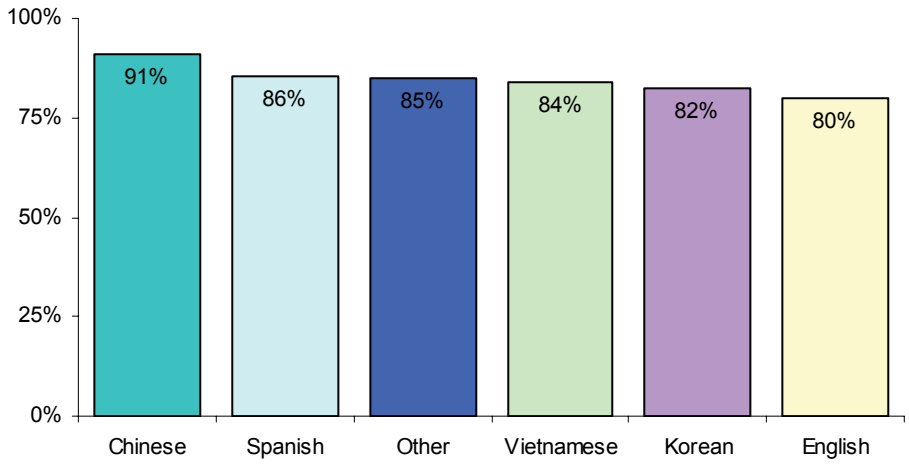
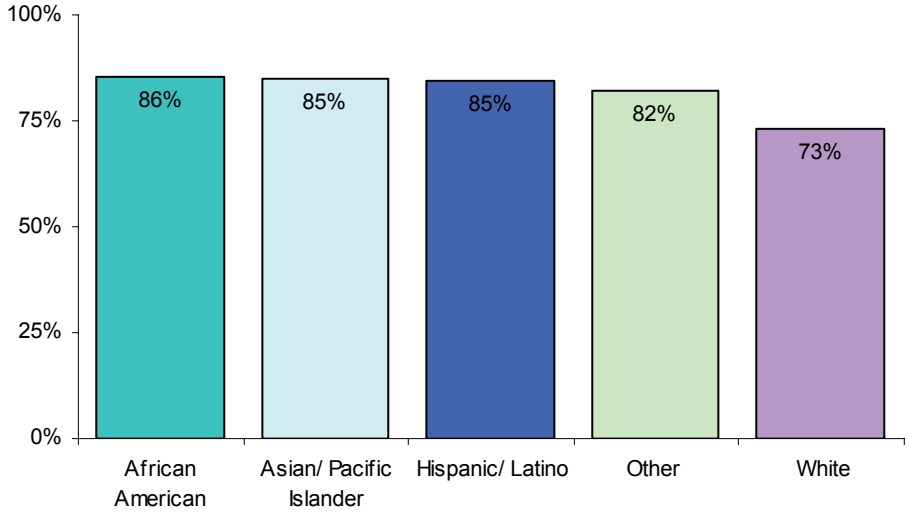


Figure 5. Childhood Immunization Status - Combination 2 by Ethnicity



Key Findings About Demographics

- There were small differences in Combination 2 immunizations rates by spoken language. However, Chinese language speakers had a higher rate than other Asian language speakers and English language speakers reported the lowest rates.
- White children received immunizations at the lowest rate, nearly ten percentage points lower than other ethnic groups.

Childhood Immunization Status, Combination 2

Figure 6. Childhood Immunization Status - Combination 2 by Region

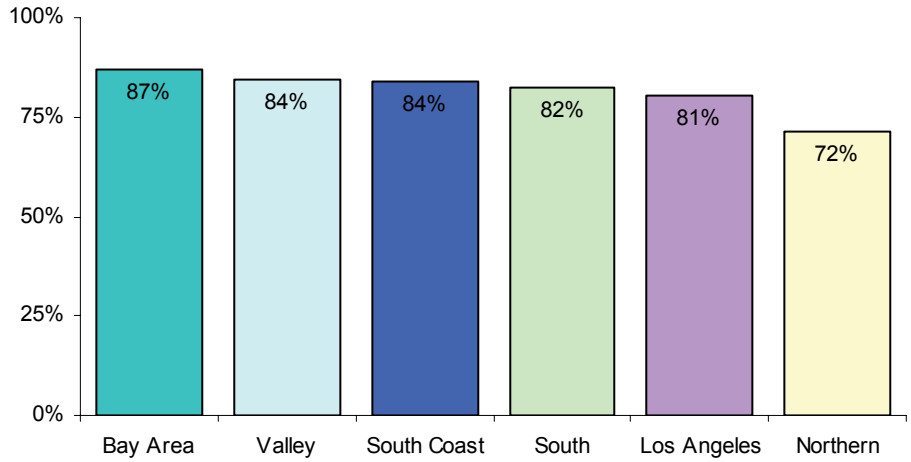


Figure 7. Childhood Immunization Status - Combination 2 by FPL Category

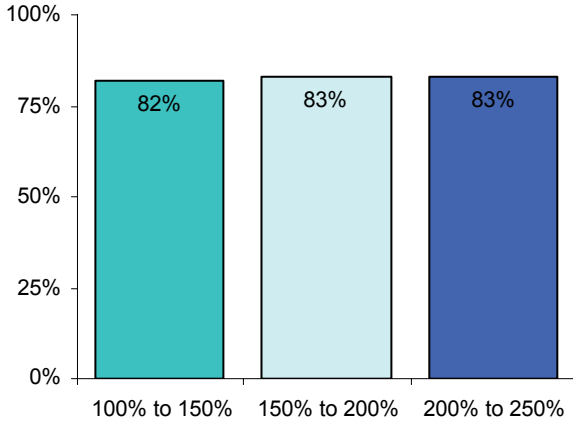
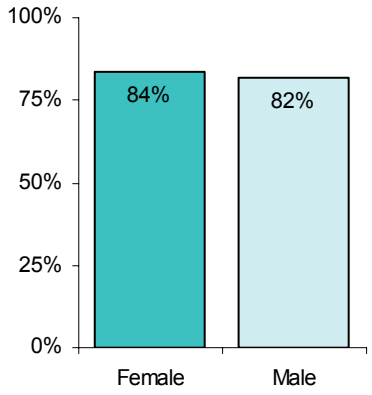


Figure 8. Childhood Immunization Status - Combination 2 by Gender



Key Findings About Demographics

- There were slight differences in immunization rates across regions except in the Northern, predominantly rural, region which had a significantly lower rate compared to the other regions.
- There was no significant difference in immunization rates based on level of household income as measured by Federal Poverty Level (FPL).
- There was also no significant difference in immunization rates by gender.

Childhood Immunization Status, Combination 3

Measure Definition

The ***Childhood Immunization Status, Combination 3*** measure assesses how many children under the age of 2 received all of the recommended Combination 2 immunizations and four pneumococcal conjugate vaccinations.

Why Is It Important?

This measure follows the Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations. [4]

Overall Results

Seventy-three percent (73%) of children under the age of two received all of the recommended Combination 3 vaccinations. This rate exceeds the national Medicaid average and is close to the national Commercial average. This represents a slight increase from 2006, however, the Combination 3 rate increased 23% from 2005, when the measure was first collected.

The table below presents the percentage of HFP children that received all of the recommended doses for the Combination 3 vaccinations.

Vaccination	Percentage of Children Who Received All Recommended Doses
Dtap	87.13%
IPV	92.36%
MMR	95.48%
Hib	93.78%
Hepatitus B	91.71%
VZV	94.65%
Pneumococcal Conjugate	84.32%

Benchmarking and Trend Analysis

Comparisons to state and national benchmarks for Combination 3 immunizations are presented in Figure 9. The HFP weighted average for Combination 3 immunizations for calendar years 2005 through 2007 are presented in Figure 10.

Figure 9. Comparison to National Benchmarks
Childhood Immunization Status - Combination 3

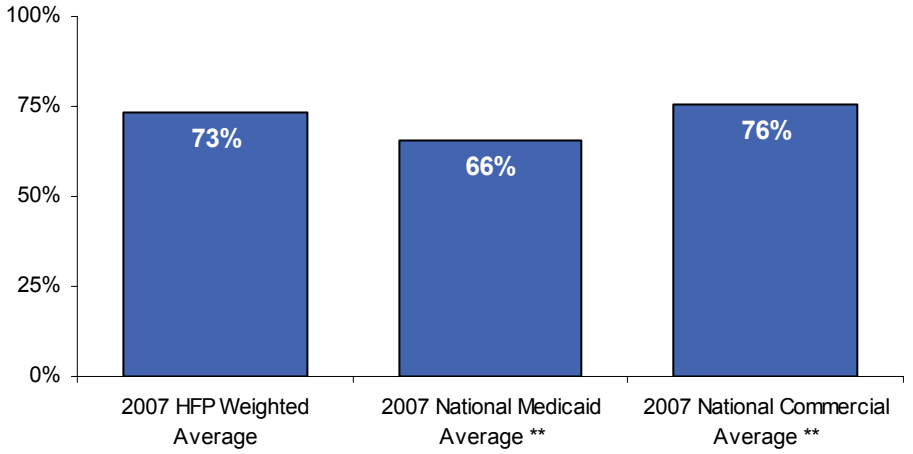
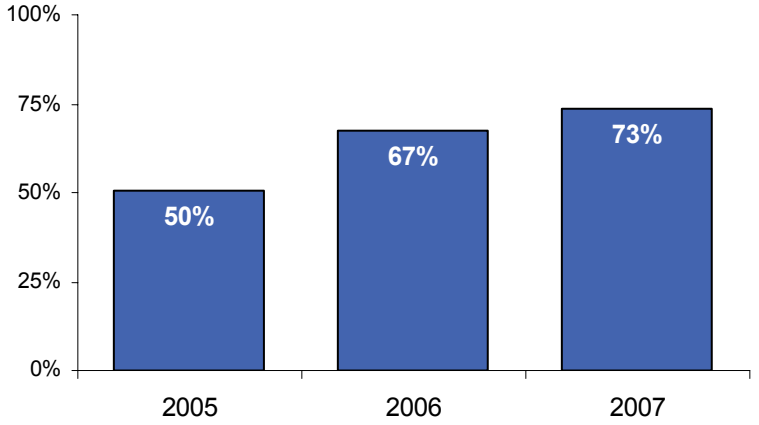


Figure 10. HFP 3 Year Trend for Childhood Immunization Status - Combination 3



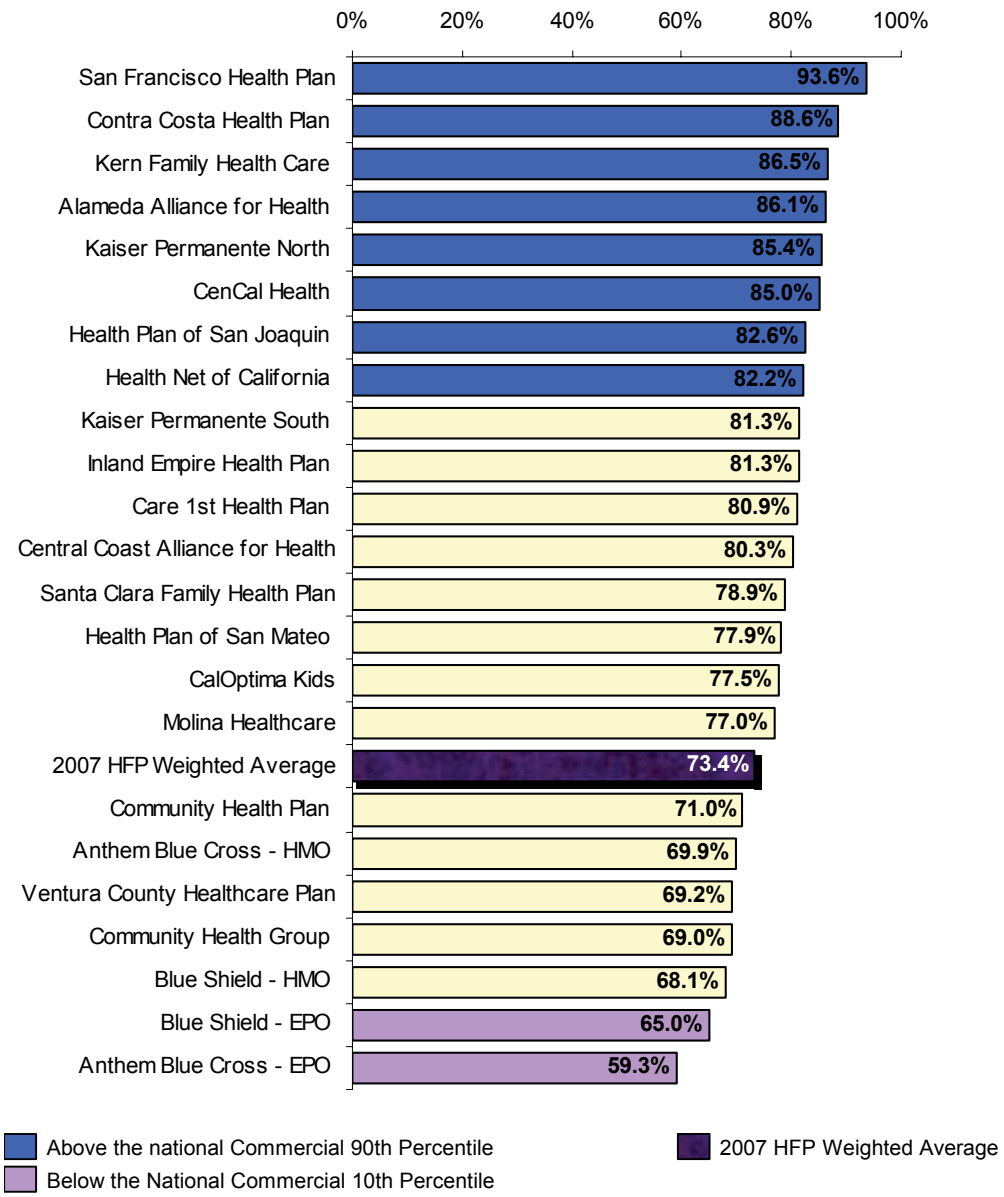
4 ACIP guidelines for Immunizations are available at: http://www.cdc.gov/vaccines/recs/schedules/downlaods/child/2008

** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Childhood Immunization Status, Combination 3

The rates below represent the percentage of children under the age of 2 who received the recommended Combination 3 vaccinations.

Figure 11. Individual Plan Rates for Childhood Immunization Status, Combination 3



Health Plan Comparison

Individual plan rates ranged from 93.6% to 59.3%.

Eight health plans had rates that were above the national Commercial 90th percentile (81.7%):

- San Francisco Health Plan
- Contra Costa Health Plan
- Kern Family Health Care
- Alameda Alliance for Health
- Kaiser Permanente North
- CenCal Health
- Health Plan of San Joaquin
- Health Net of California

Two health plans had rates that were below the national Commercial 10th percentile (65.5%):

- Blue Shield - EPO
- Anthem Blue Cross - EPO

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 12. Childhood Immunization Status - Combination 3 by Spoken Language

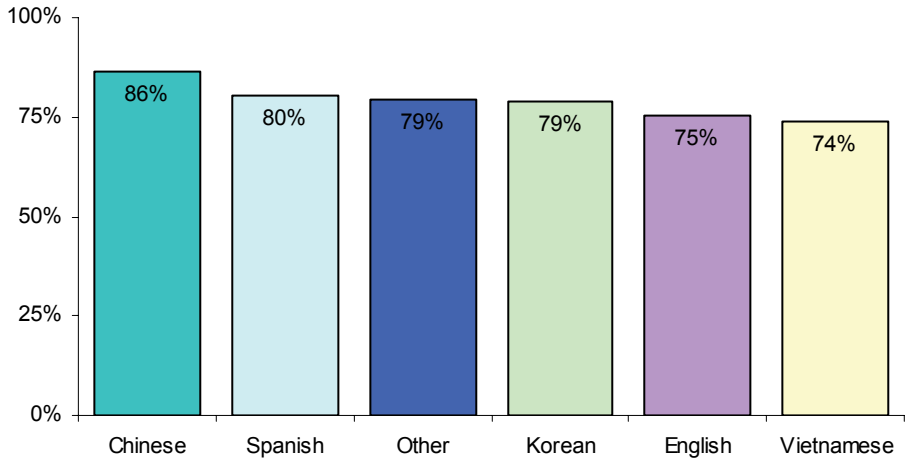
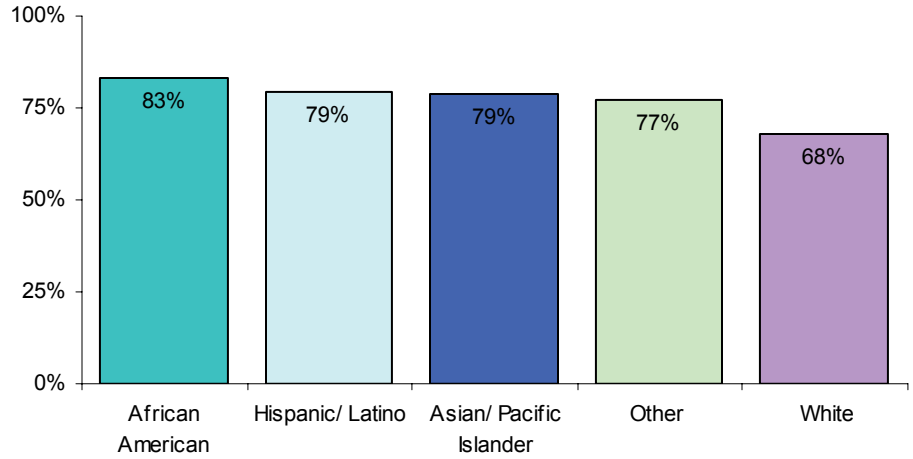


Figure 13. Childhood Immunization Status - Combination 3 by Ethnicity



Key Findings About Demographics

- There were small differences in Combination 3 immunizations rates by spoken language. However, Chinese language speakers had a higher rate than other language speakers.
- White children received immunizations at the lowest rate, which was nearly ten percentage points lower than other ethnic groups.

Childhood Immunization Status, Combination 3

Figure 14. Childhood Immunization Status - Combination 3 by Region

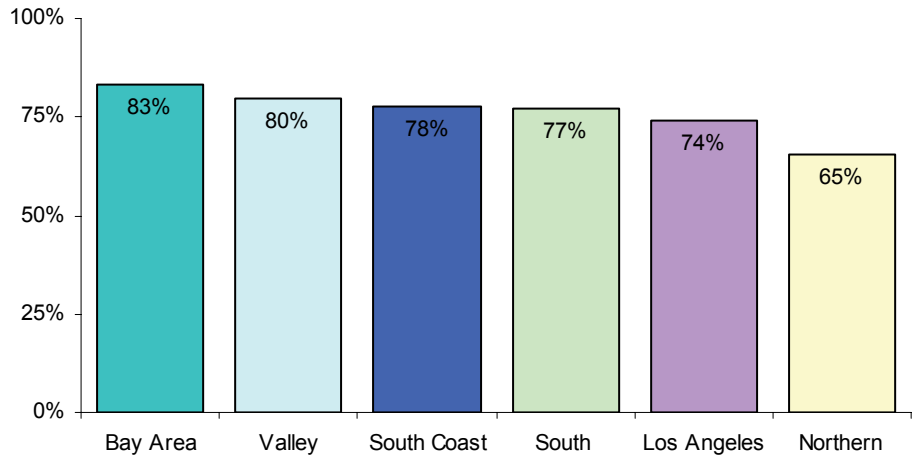


Figure 15. Childhood Immunization Status - Combination 3 by FPL

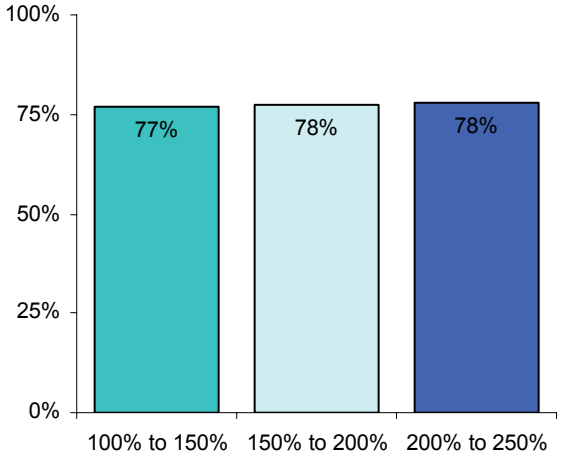
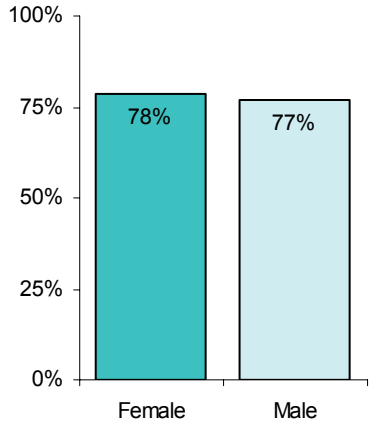


Figure 16. Childhood Immunization Status - Combo 3 by Gender



Key Findings About Demographics

- There were slight differences in immunization rates across regions except in the Northern region, which had a significantly lower rate compared to the other regions.
- There was no significant difference in immunization rates by FPL.
- There was also no significant difference in immunization rates by gender.

Well-Child Visits in the First 15 Months of Life

Measure Definition

The ***Well-Child Visits in the First 15 Months of Life*** measure assesses how many children had six or more well-child visits with a Primary Care Practitioner (PCP) during their first 15 months of life.

Why Is This Important?

The American Academy of Pediatrics (AAP) recommends that children receive 6 well-child visits in the first year of life beginning in the first month of life followed by a visit at 2, 4, 6, 9 and 12 months of age. [5] "Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents...These visits are particularly important during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth." [6]

Overall Results

Fifty-seven percent (57%) of children had six or more well-child visits with a PCP during their first 15 months of life. However, the majority of HFP children (91.7%) received at least 4 well-child visits during their first 15 months of life. This is essentially the same as the Medi-Cal Managed Care weighted average and the national Medicaid average, but is significantly below the national Commercial average. However, it is a significant increase from 2006, when this measure was first collected for HFP.

Benchmarking and Trend Analysis

Comparisons to state and national benchmarks are presented in Figure 17. The HFP weighted average for calendar years 2006 through 2007 are presented in Figure 18.

Figure 17. Comparison to State and National Benchmarks Well-Child Visits in the First 15 Months of Life

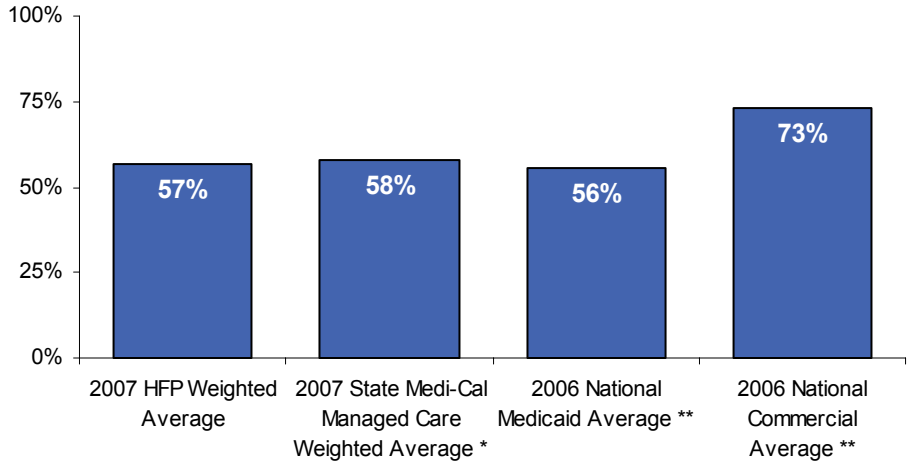
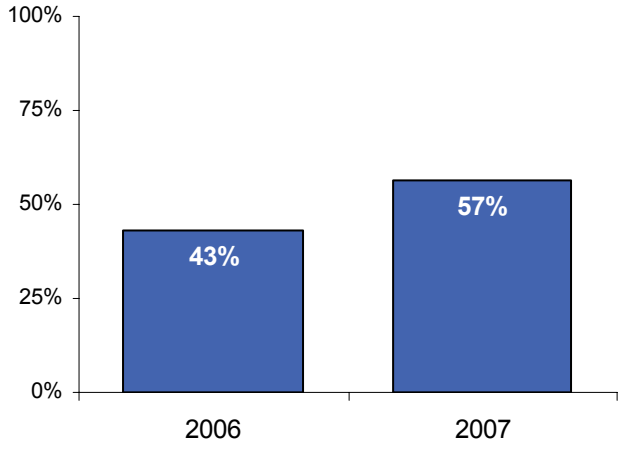


Figure 18. HFP 2 Year Trend for Well-Child Visits in the First 15 Months of Life



5 Recommendations for Preventive Pediatric Health Care available at http://practice.aap.org.

6 NCQA's HEDIS® 2009, Volume 1: Narrative

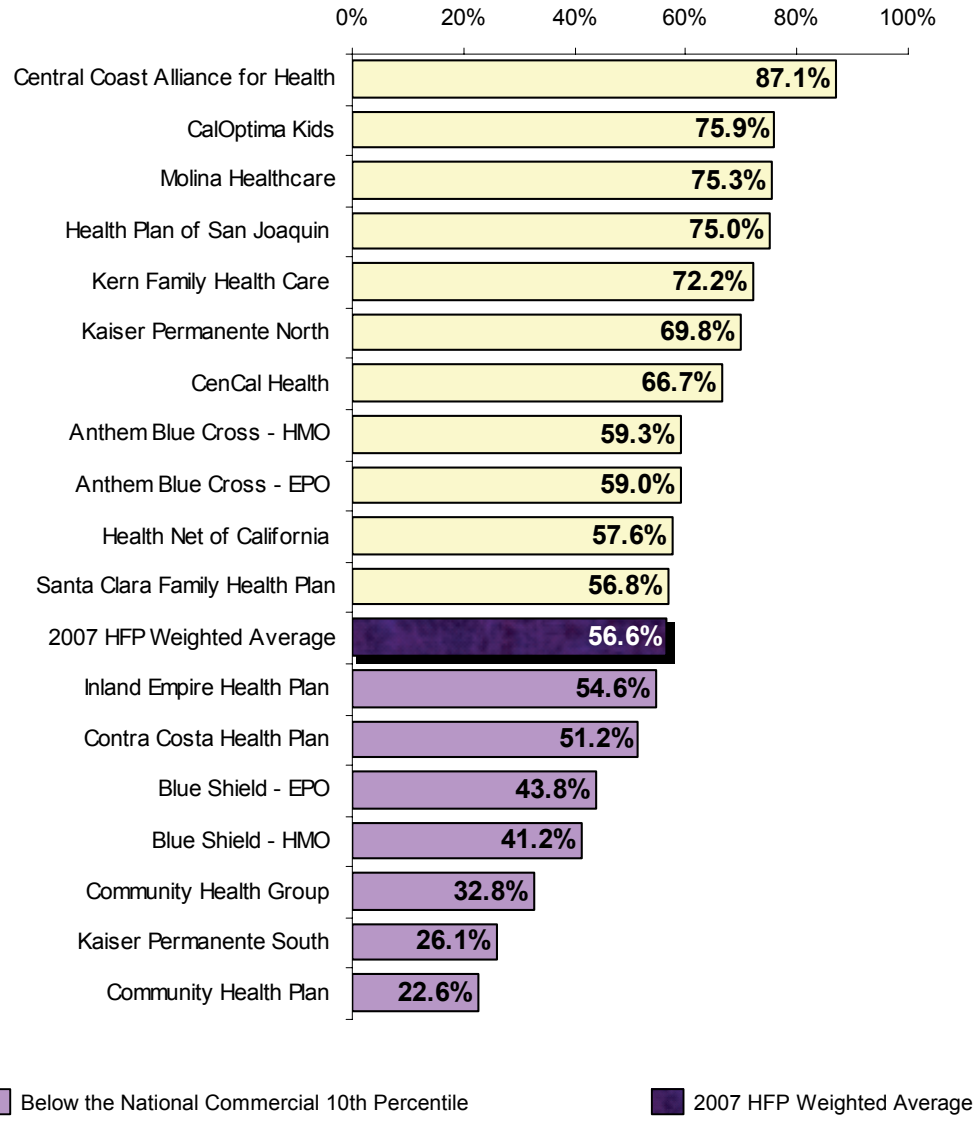
* Rate obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*

** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Well-Child Visits in the First 15 Months of Life

The rates below represent the percentage of children who received 6 or more well-child visits during their first 15 months of life

Figure 19. Individual Plan Rates for Well-Child Visits in the First 15 Months of Life



Health Plan Comparison

Individual plan scores ranged from 87.1% to 22.6%.

There were no plans that had rates that were above the national Commercial 90th percentile (88.6%).

Seven health plans had rates that were below the national Commercial 10th percentile (55.6%):

- Inland Empire Health Plan
- Contra Costa Health Plan
- Blue Shield - EPO
- Blue Shield - HMO
- Community Health Group
- Kaiser Permanente South
- Community Health Plan

Kaiser North had rates significantly higher than the HFP weighted average, while Kaiser South had rates significantly below.

The following plans had a sample size of less than 30 and were not included in the analysis:

- Alameda Alliance for Health
- Health Plan of San Mateo
- L.A. Care Health Plan
- San Francisco Health Plan
- Care 1st Health Plan
- Ventura County

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 20. Well-Child Visits in the First 15 Months of Life by Spoken Language

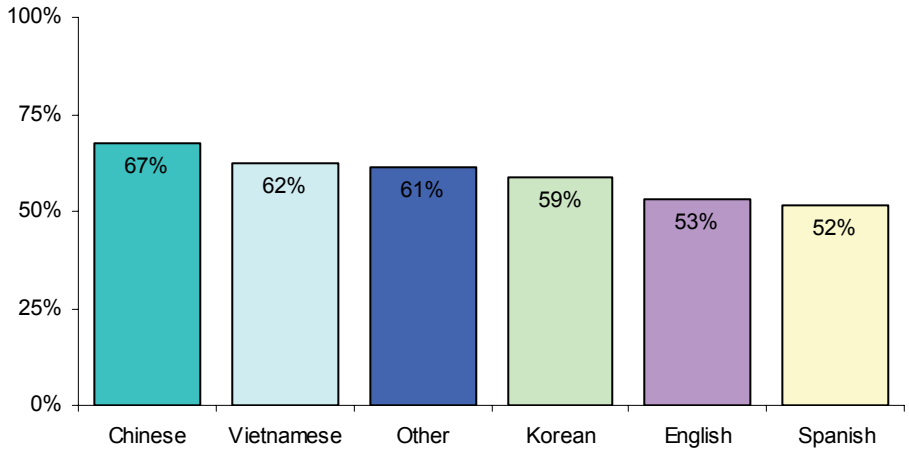
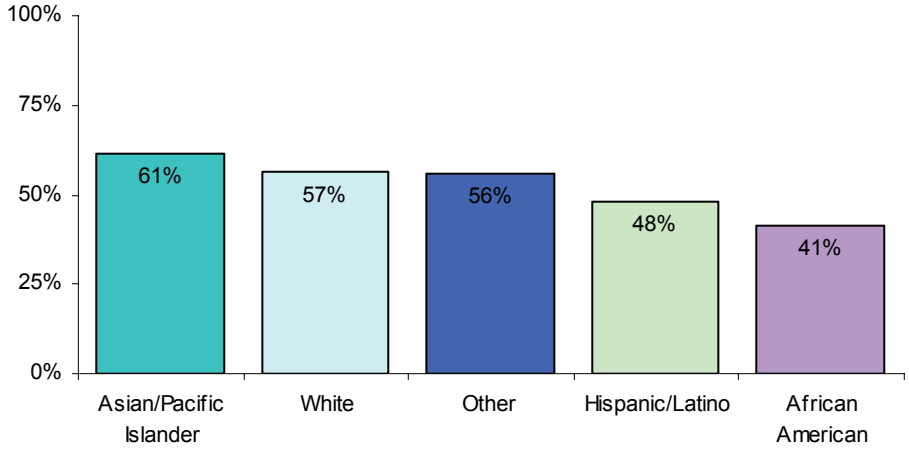


Figure 21. Well-Child Visits in the First 15 Months of Life by Ethnicity



Key Findings About Demographics

- Fifty-seven percent (57%) of HFP children received 6 or more well-child visits in the first 15 months of life.
- Asian language speakers were more likely to have received 6 or more well-child visits compared to English and Spanish speakers who had the lowest rates.
- Six out of ten children who were Asian/Pacific Islander received 6 or more visits compared to four of every ten African-American children.

Figure 22. Well-Child Visits in the First 15 Months of Life by Region

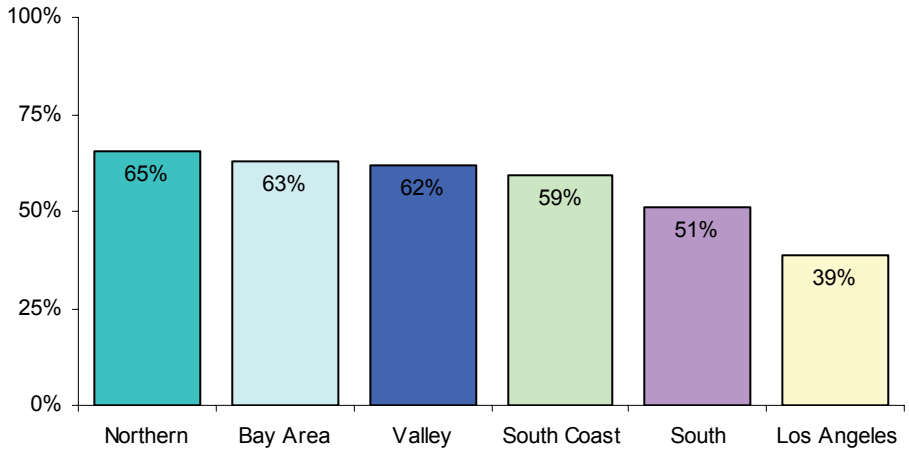


Figure 23. Well-Child Visits in the First 15 Months of Life by FPL

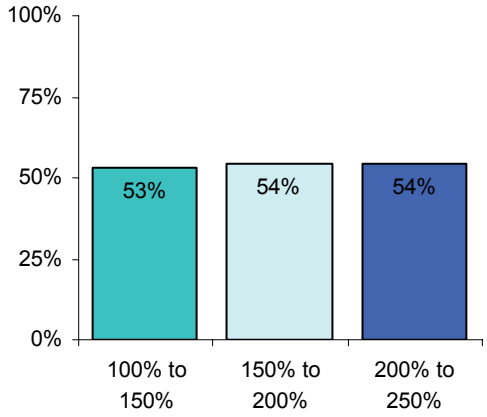
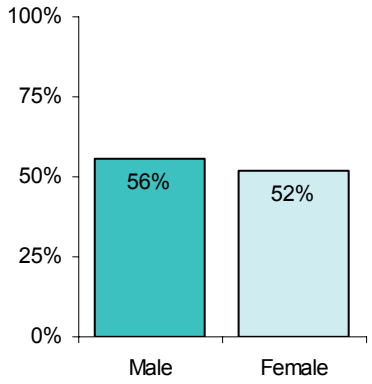


Figure 24. Well-Child Visits in the First 15 Months of Life by Gender



Key Findings About Demographics

- Children in the Southern California regions, particularly Los Angeles, were less likely to have received all 6 well-child visits compared to the Northern California regions.
- There was no significant difference in the number of children that received 6 or more well-child visits by FPL.
- Males received all 6 recommended well-child visits at a slightly higher rate than females.

Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life

Measure Definition

The ***Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*** measure assesses how many children ages 3 to 6 years old received at least one well-child visit with a PCP.

Why Is This Important?

The American Academy of Pediatrics (AAP) recommends that children receive annual well-child visits.[7] "Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems." [8]

Results

Approximately seventy-three percent (73%) of HFP children between the ages of three and six years old had at least one visit with a PCP each year, a slight increase over the last 2 years. This is about the same rate as the state Medi-Cal Managed Care weighted average and exceeds both the national Medicaid and Commercial averages.

Benchmarking and Trend Analysis

Comparisons to state and national benchmarks are presented in Figure 25. The HFP weighted average for calendar years 2005 through 2007 are presented in Figure 26.

Figure 25. Comparison to State and National Benchmarks Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life

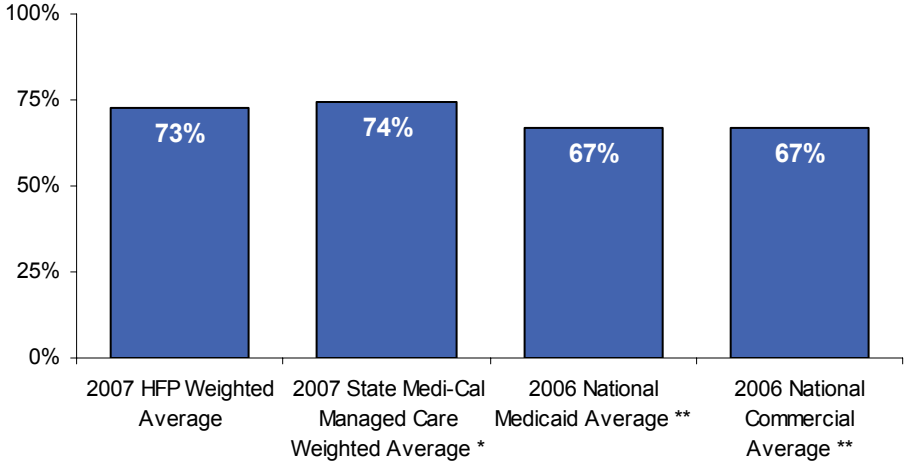
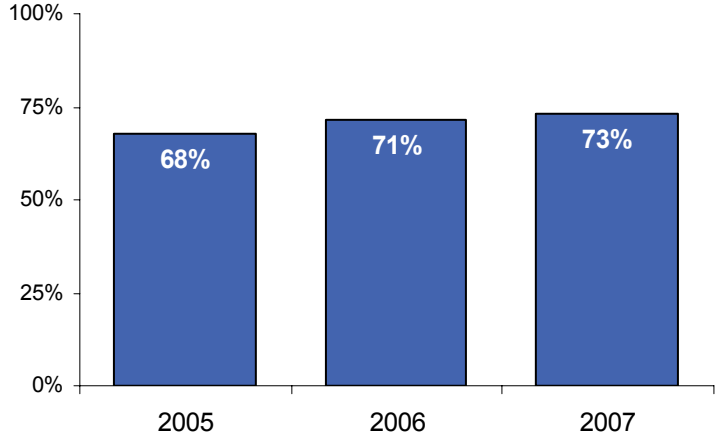


Figure 26. HFP 3 Year Trend for Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life



7 Recommendations for Preventive Pediatric Health Care available at http://practice.aap.org.

8 NCQA's HEDIS® 2009, Volume 1: Narrative

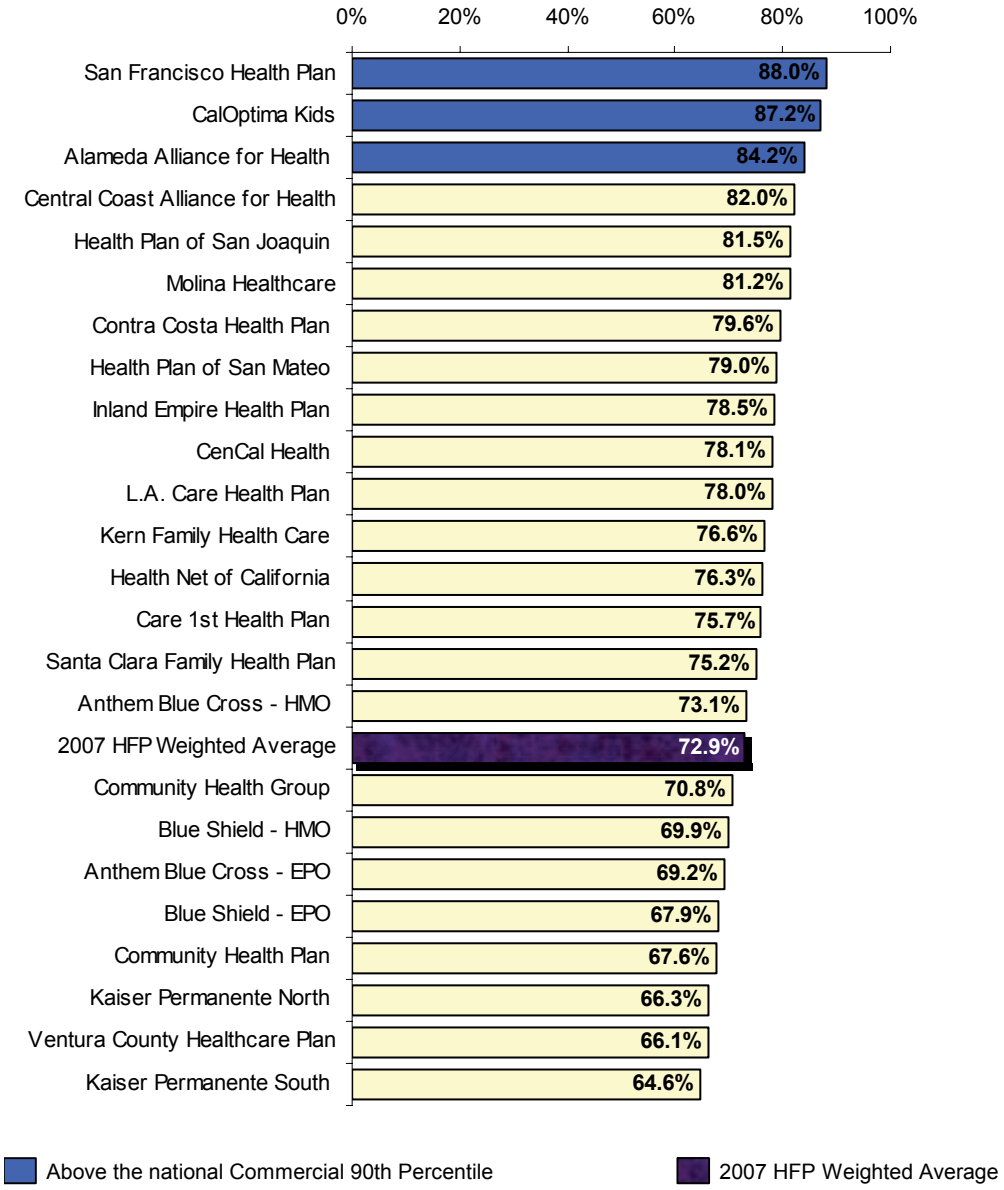
* Rate obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*

** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life

The rates below represent the percentage of children ages 3, 4, 5 or 6 who received at least one well-child visits with a PCP.

Figure 27. Individual Plan Rates for Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life



Health Plan Comparison

Individual plan rates ranged from 88% to 64.6%.

Three health plans had rates that were above the national Commercial 90th percentile (83.3%):

- San Francisco Health Plan
- CalOptima Kids
- Alameda Alliance for Health

There were no health plans that had rates that were below the national Commercial 10th percentile (50.5%).

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 28. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life, by Spoken Language

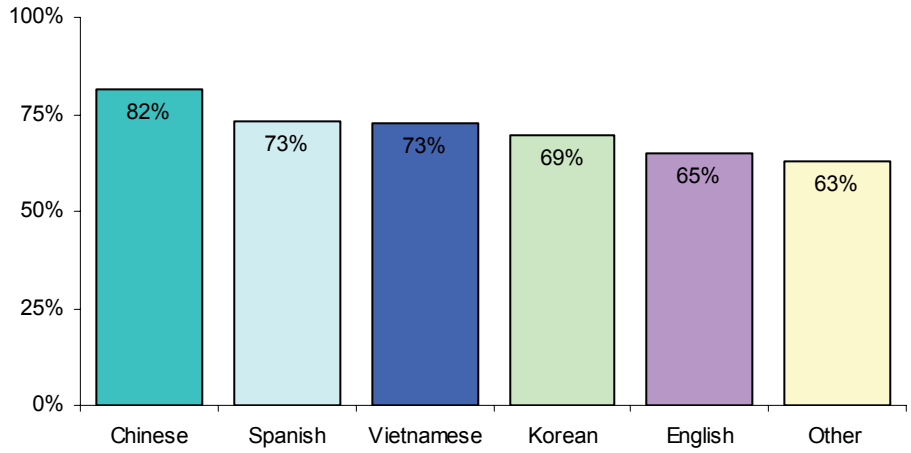
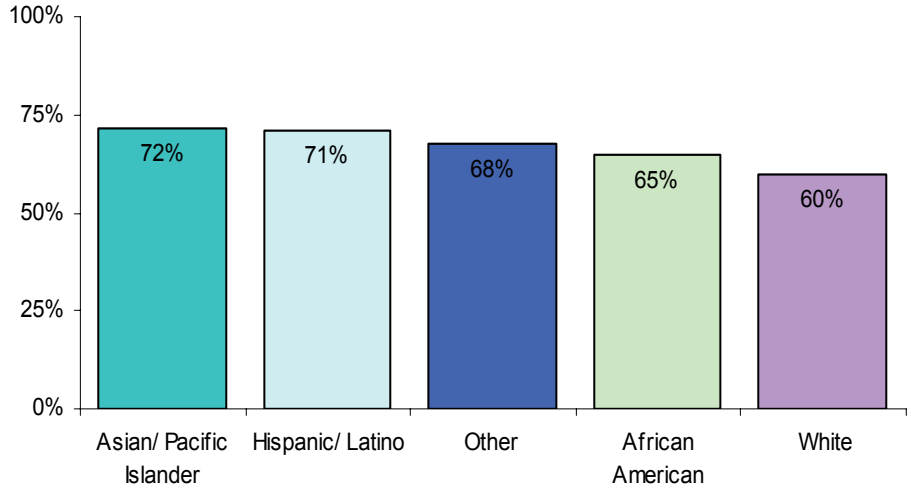


Figure 29. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life by Ethnicity



Key Findings About Demographics

- Chinese language speakers received well-child visits at a much higher rate compared to English speakers and those that spoke Other languages.
- Asian/Pacific Islander and Hispanic/ Latino children were more likely to have received a well-child visit compared to White children.

Figure 30. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life by Region

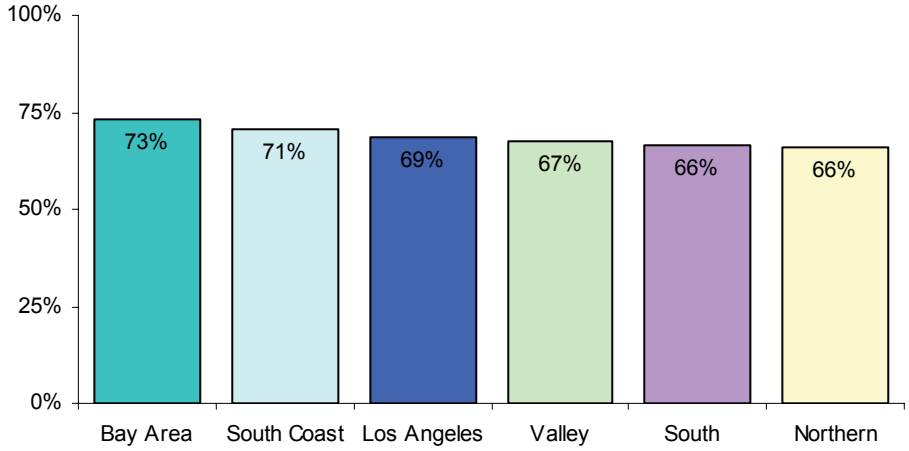


Figure 31. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life by Age

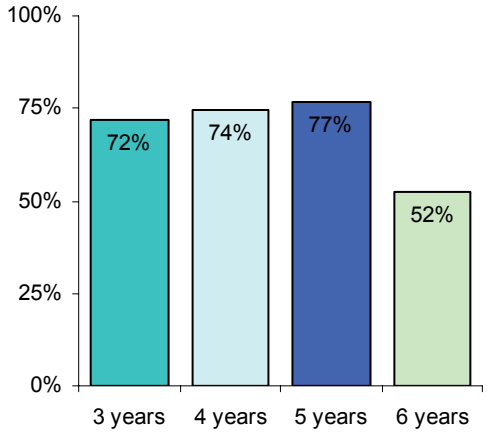
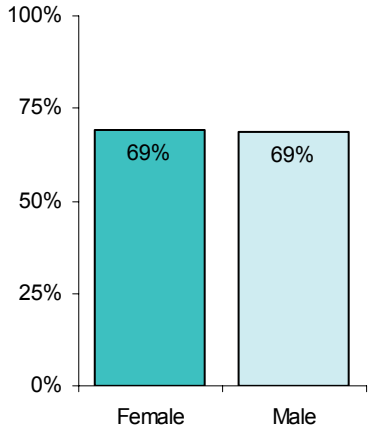


Figure 32. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life by Gender



Key Findings About Demographics

- There were minimal differences by region in the percentage of children ages 3 to 6 who received a well-child visit. However, children in the Bay Area saw a PCP at a slightly higher rate.
- Five year olds received well-child visits at the highest rate, possibly due to the Kindergarten enrollment requirements.
- There was no significant difference by gender .
- Only about half of 6 year olds had a visit with a PCP, compared to more than three-quarters of 5 year olds. However, there were 6 health plans that had significantly higher rates for 6 year olds with rates over 70%. These plans were:
  - San Francisco Health Plan (76.3%)
  - Blue Cross - HMO (74.6%)
  - CalOptima Kids (74.6%)
  - Molina Healthcare (74%)
  - Central Coast Alliance for Health (71.9%)
  - L.A. Care Health Plan (71.7%)

Adolescent Well-Care Visits

Measure Definition

The ***Adolescent Well-Care Visits*** measure estimates the percentage of adolescents ages 12 to 18 years of age who had one or more well-care visits with a PCP or OB/GYN.

Why Is This Important?

The American Medical Association's Guidelines for Adolescent Preventive Services and the AAP recommend that adolescents receive annual check-ups. [9]"Adolescence is a time of transition between childhood and adult life and is accompanied by dramatic changes. Accidents, homicide and suicide are the leading causes of adolescent deaths. Sexually transmitted diseases, substance abuse, pregnancy and anti-social behavior are important causes of –or result from—physical, emotional and social adolescent problems." [10]

Results

Forty-four percent (44%) of adolescents between the ages of 12 and 18 received at least one visit with a PCP or OB/GYN. This is the same as the national Medicaid average but exceeds both the state Medi-Cal Managed Care average and the national Medicaid and Commercial average. Historically, we have found that adolescents receive well-care visits at a very low rate, however, the HFP rate has steadily increased by 3-4% since this measure was first reported in 2005.

Benchmarking and Trend Analysis

Comparisons to state and national benchmarks are presented in Figure 33. The HFP weighted average for calendar years 2005 through 2007 are presented in Figure 34.

Figure 33. Comparison to State and National Benchmarks Adolescent Well-Care Visits

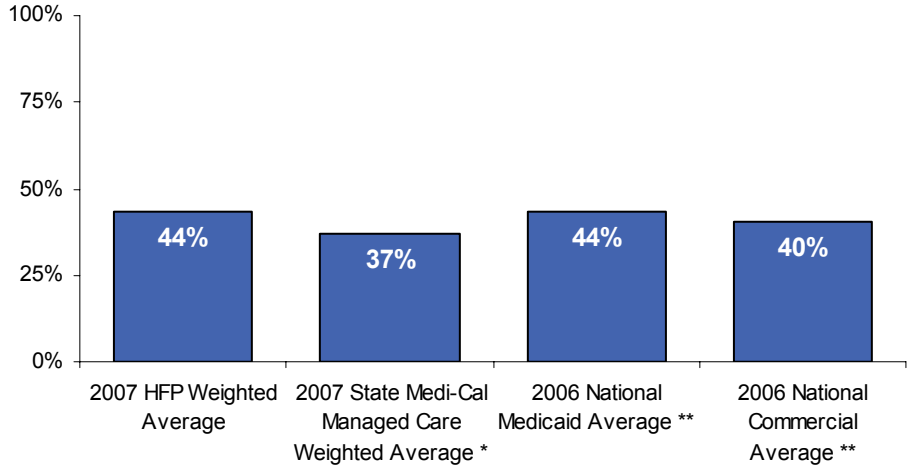
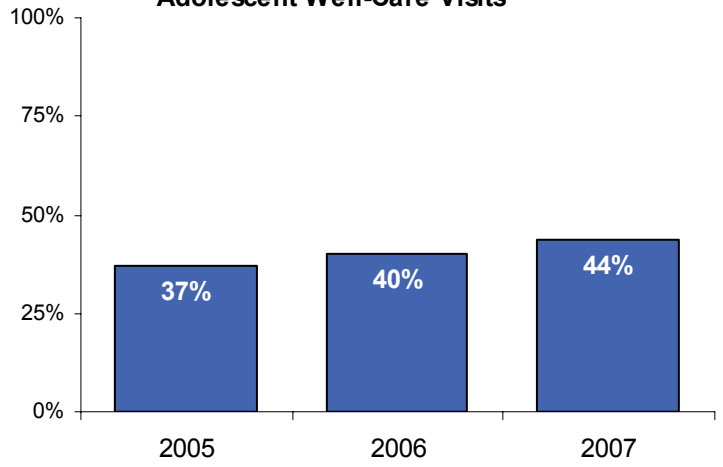


Figure 34. HFP 3 Year Trend for Adolescent Well-Care Visits



9 American Medical Association. Guidelines for Preventive Health Services available at http://www.ama-assn.org/ama/pub/category/1980.html

10 NCQA's HEDIS® 2009, Volume 1: Narrative

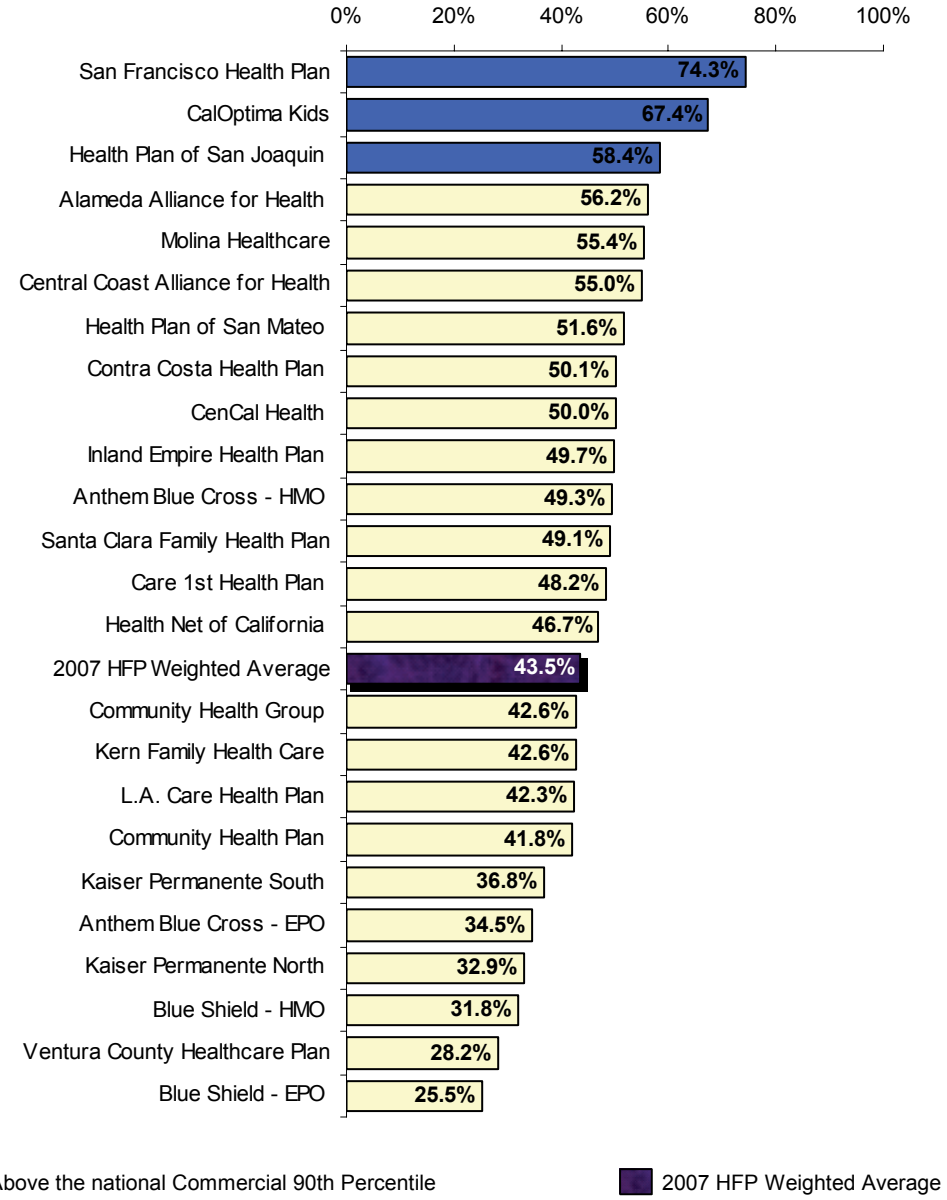
* Rate obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*

** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Adolescent Well-Care Visits

The rates below represent the percentage of adolescents ages 12 to 18 years of age who had one or more well-care visits with a PCP or OB/GYN.

Figure 35. Individual Plan Rates for Adolescent Well-Care Visits



Health Plan Comparison About Demographics

Individual health plan rates ranged from 74.3% to 25.5%.

Three health plans had rates that were above the national Commercial 90th percentile (57.8%):

- San Francisco Health Plan
- CalOptima Kids
- Health Plan of San Joaquin

There were no plans that had rates that were below the national Commercial 10th percentile (25.1%).

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 36. Adolescent Well-Care Visits by Spoken Language

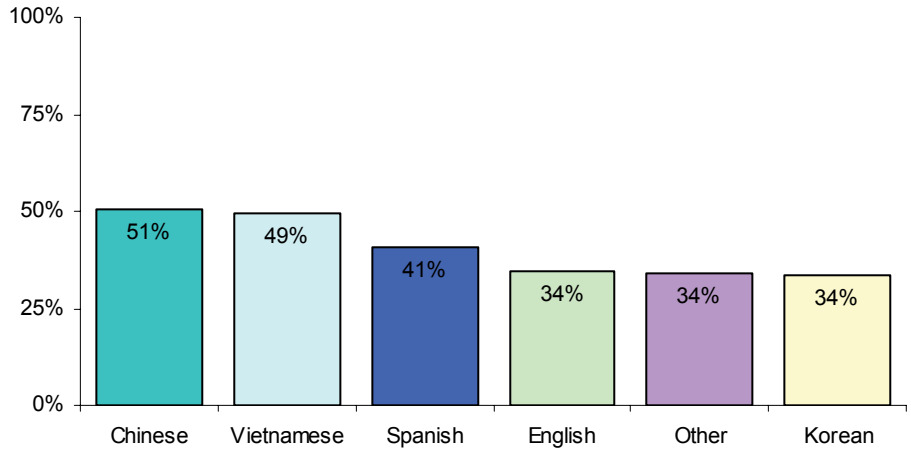
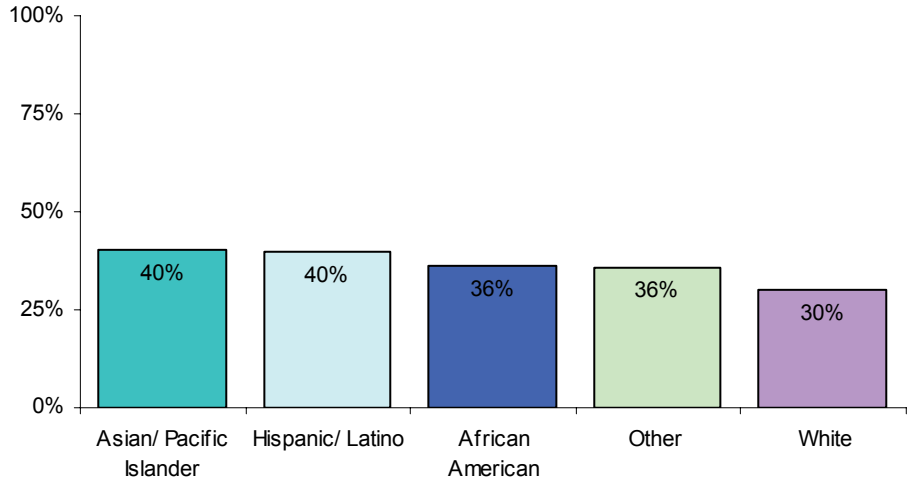


Figure 37. Adolescent Well-Care Visits by Ethnicity



Key Findings About Demographics

- Half of Chinese and Vietnamese speaking teens received a well-care visit compared to only one-third of English, Korean and Other language speakers.
- Forty percent (40%) of Asian/Pacific Islander and Hispanic teens received a well-care visit compared to 30% of White teens.

Figure 38. Adolescent Well-Care Visits by Region

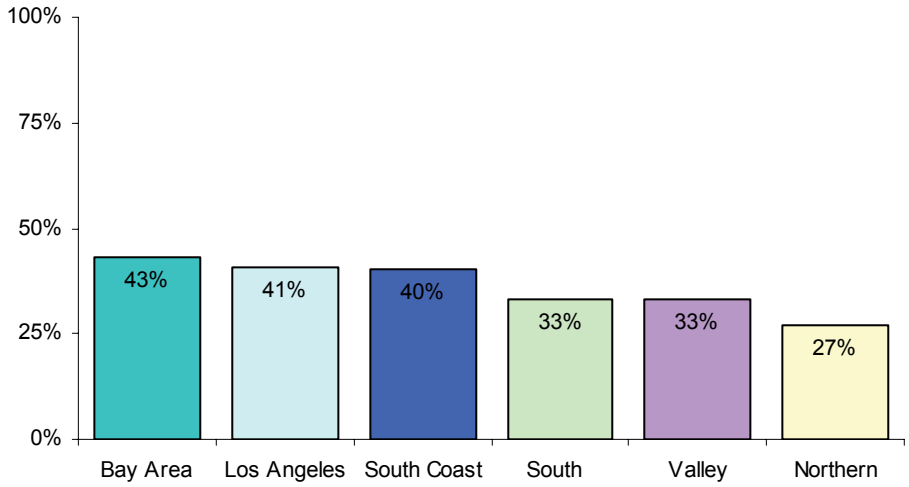
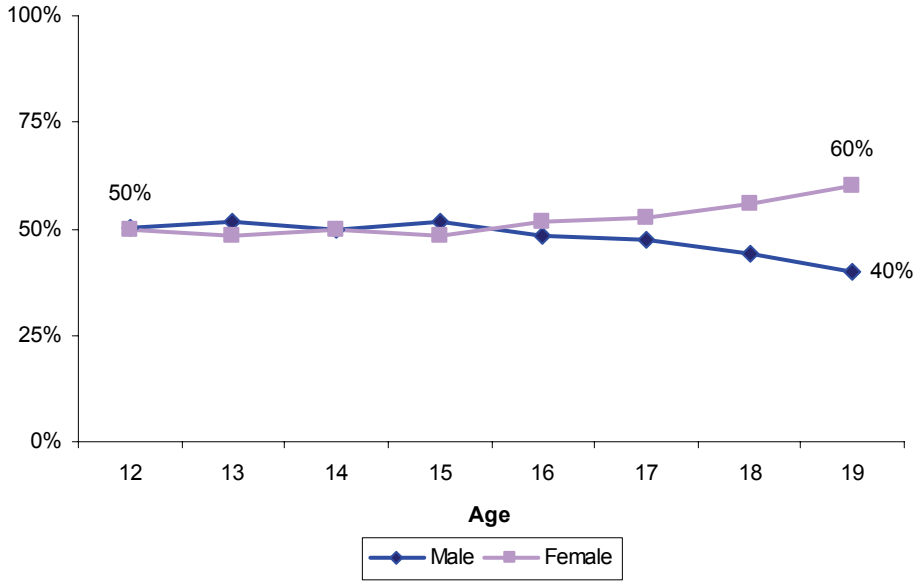


Figure 39. Adolescent Well-Care Visits by Age and Gender



Key Findings About Demographics

- Adolescents received well-care visits at a significantly lower rate in the Northern region.
- Males received well-care visits at the highest rate at age 13 and 15, where females of the same age received well-care visits at the lowest rate.
- Males were less likely to receive well-care visits as their age increased.
- The opposite was true of females, who were more likely to have had a well-care visit as their age increased.
- Fifty-six percent (56%) of 18 year old females received a well-care visit compared to only 44% of males.

Children and Adolescents' Access to Primary Care Practitioners, Ages 12 to 24 Months

Measure Definition

The ***Children and Adolescents' Access to Primary Care Practitioners, Ages 12 to 24 Months*** measure assesses how many children ages 12 to 24 months had a visit with a primary care practitioner in 2007.

Why Is This Important?

Doctor's visits provide an opportunity for the provider and the child to develop a relationship and an important opportunity to provide counseling on topics such as diet, exercise and risky behaviors. This measure also provides a convincing argument for the importance of health insurance. Without the Healthy Families Program, these children would have ended up in emergency rooms or gone untreated, resulting in missed days of school and poor health.

Results

Nearly all of HFP children (97%) ages 12 to 24 months had a visit with a PCP during the measurement year. While a little over half received the recommended 6 or more well-child visits in the first 15 months of life, this is an indication that the youngest children are receiving needed care from their doctor. This rate exceeds the national Medicaid average and is comparable to the national Commercial averages.

Benchmarking and Trend Analysis

Comparisons to national benchmarks are presented in Figure 40 and trends for 2005 through 2007 are presented in Figure 41.

Figure 40. Comparison to National Benchmarks for Children's Access to PCP, 12 - 24 Months

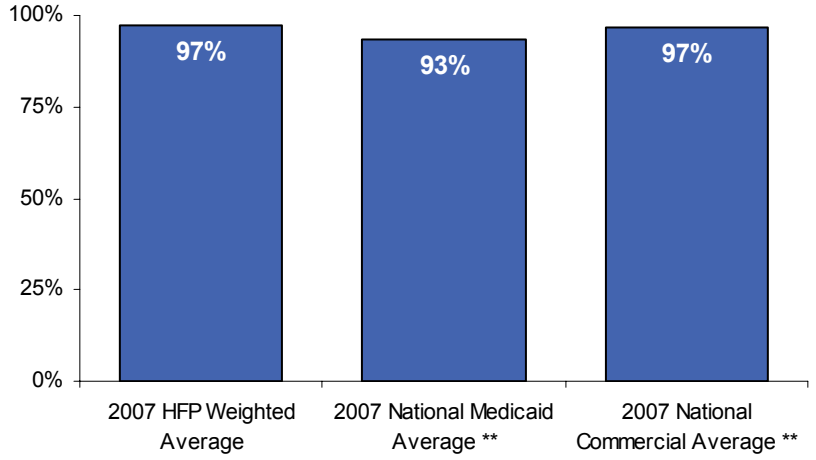
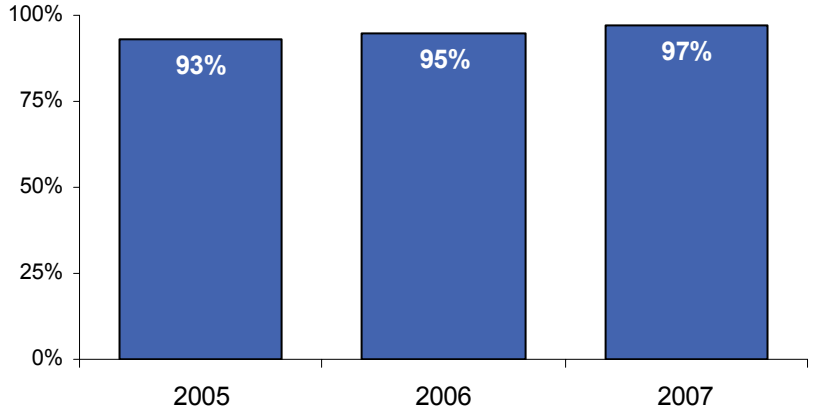


Figure 41. HFP 3 Year Trend for Children and Adolescents Access to PCP, Ages 12 to 24 Months

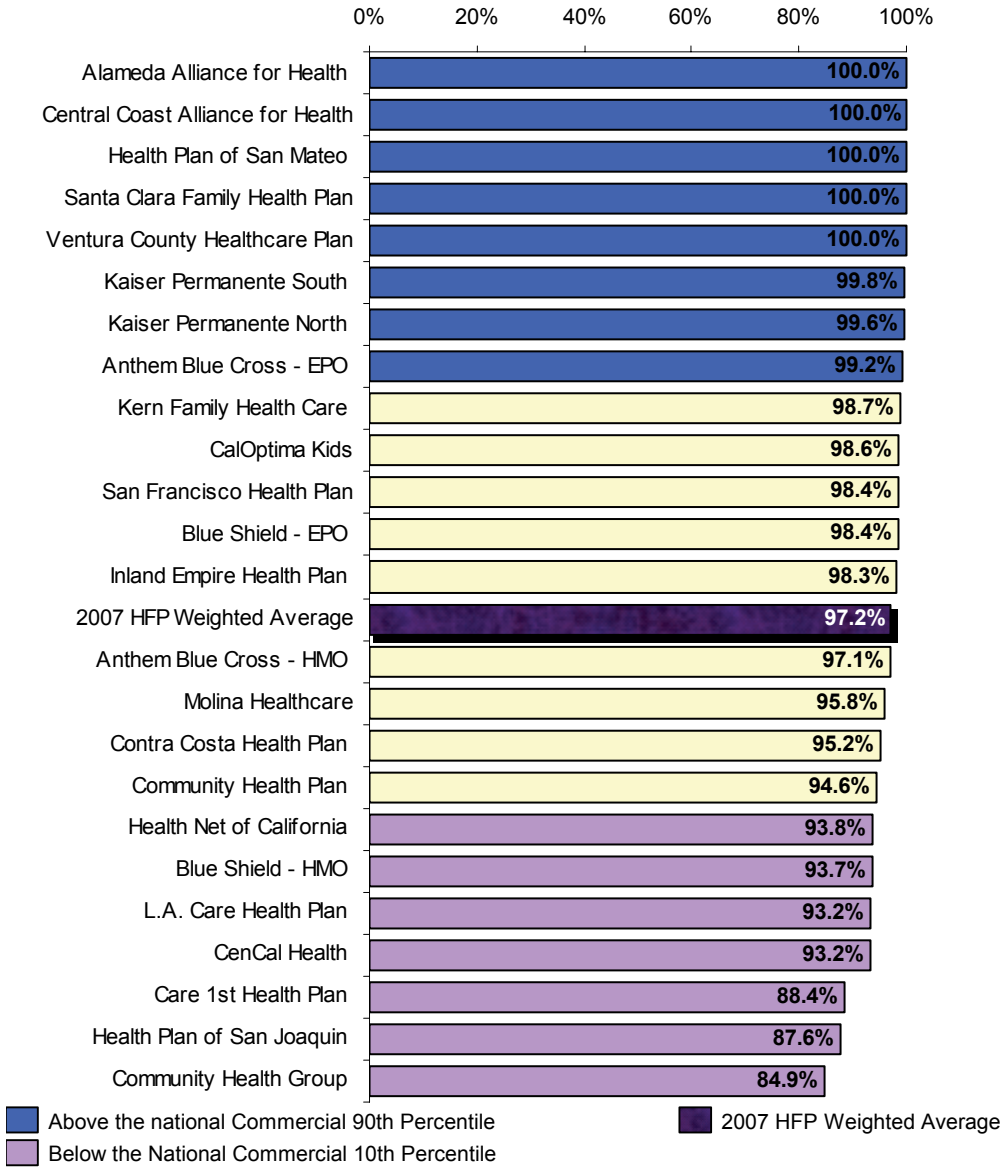


** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Children and Adolescents' Access to Primary Care Practitioners, Ages 12 to 24 Months

The rates below represent the percentage of children ages 12 to 24 months who had at least one visit with a PCP.

Figure 42. Individual Plan Rates for Children and Adolescents' Access to PCP, Ages 12 to 24 Months



Health Plan Comparison

There was minimal variation in individual plan rates with rates ranging from 100% to 84.9%.

Five health plans had a rate of 100%.

Eight health plans had rates that were above the national Commercial 90th percentile (99.1%):

- Alameda Alliance for Health
- Central Coast Alliance for Health
- Health Plan of San Mateo
- Santa Clara Family Health Plan
- Ventura County Healthcare Plan
- Kaiser Permanente South
- Kaiser Permanente North
- Anthem Blue Cross - EPO

Seven plans had rates that were below the national Commercial 10th percentile (94.1%):

- Health Net of California
- Blue Shield - HMO
- L.A. Care Health Plan
- CenCal Health
- Care 1st Health Plan
- Health Plan of San Joaquin
- Community Health Group

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 43. Children and Adolescents' Access to PCP, Ages 12 to 24 Months by Spoken Language

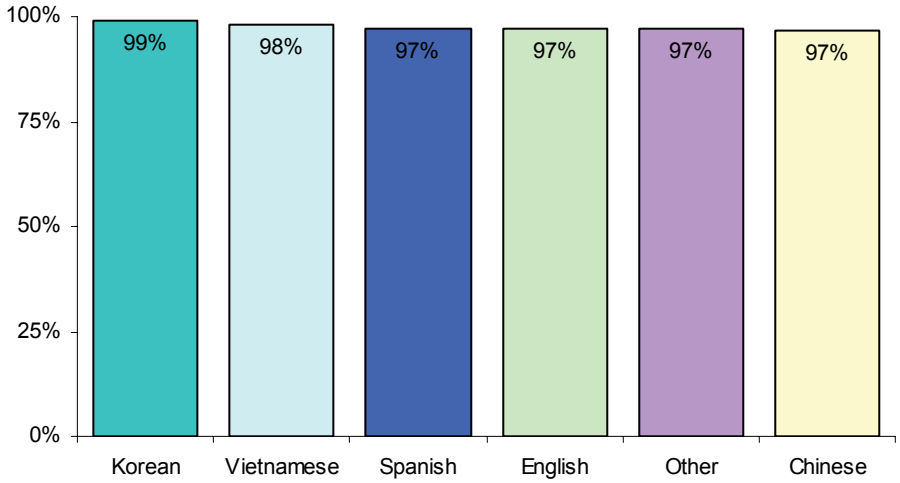
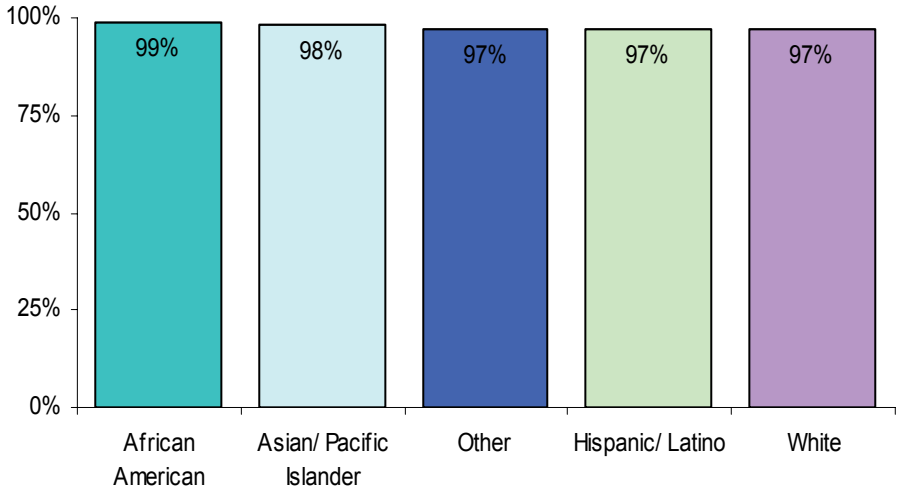


Figure 44. Children and Adolescents' Access to PCP, Ages 12 to 24 Months by Ethnicity



Key Findings About Demographics

- There was no significant difference in the number of children who had a visit with a primary care practitioner by spoken language or ethnicity.

Figure 45. Children and Adolescents' Access to PCP, Ages 12 to 24 Months by Region

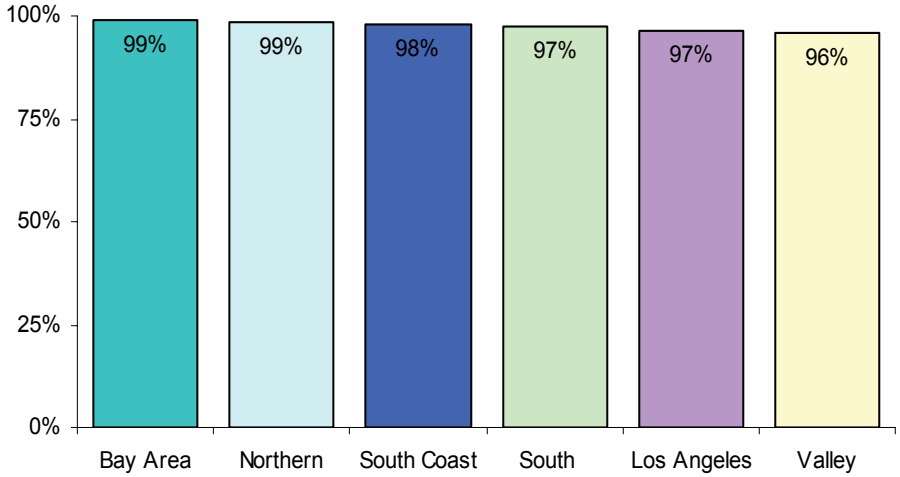


Figure 46. Children and Adolescents' Access to PCP, Ages 12 to 24 Months by FPL

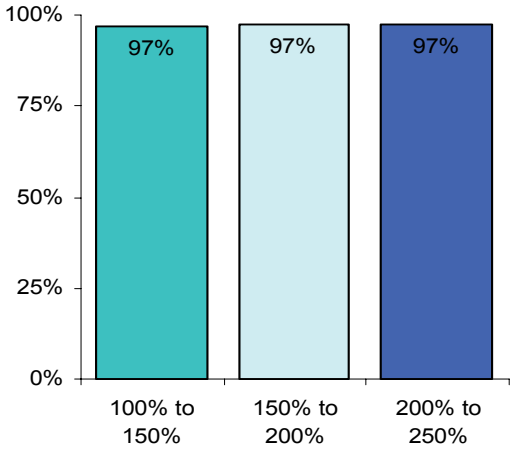
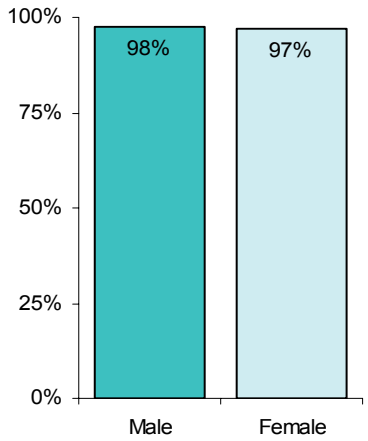


Figure 47. Children and Adolescents' Access to PCP, Ages 12 to 24 Months by Gender



Key Findings About Demographics

- There is no real difference in rates by region.
- There was no significant difference by FPL.
- Males and females received care at the same rate.

Children and Adolescents' Access to Primary Care Practitioners, Ages 25 Months to 6 Years

Measure Definition

The ***Children and Adolescents' Access to Primary Care Practitioner, Ages 25 Months to 6 Years*** measure assesses how many children ages 25 months to 6 years had a visit with a primary care practitioner in 2007.

Why Is This Important?

Doctor's visits provide an opportunity for the provider and the child to develop a relationship and an important opportunity to provide counseling on topics such as diet, exercise and risky behaviors. This measure also provides a convincing argument for the importance of health insurance. Without the Healthy Families Program, these children would have ended up in emergency rooms or gone untreated, resulting in missed days of school and poor health.

Results

Nearly all HFP children (97%) ages 25 months to 6 years had a visit with a PCP during the measurement year. This rate exceeds the national Medicaid average and is comparable to the national Commercial averages.

Benchmarking and Trend Analysis

Comparisons to national benchmarks are presented in Figure 48 and trends for 2005 through 2007 are presented in Figure 49.

Figure 48. Comparison to National Benchmarks for Children's Access to PCP, 25 Months to 6 Years

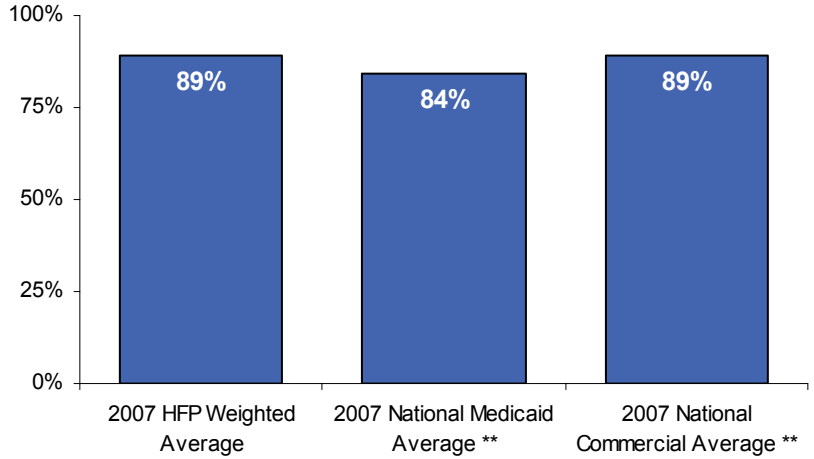
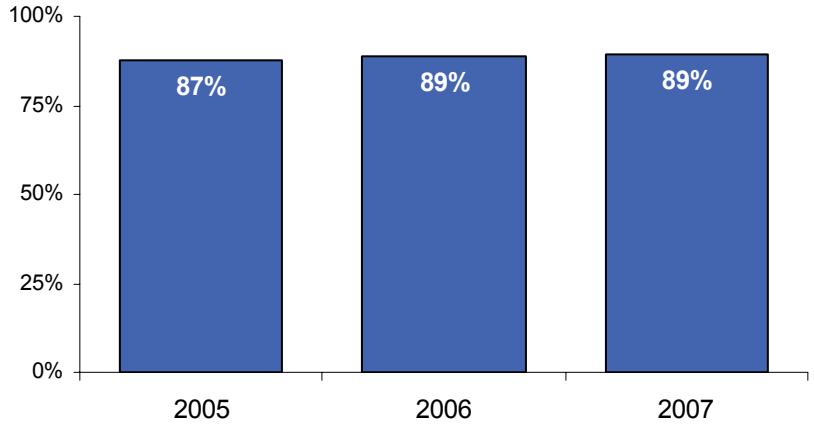


Figure 49. HFP 3 Year Trend for Children and Adolescents Access to PCP, Ages 25 Months to 6 Years

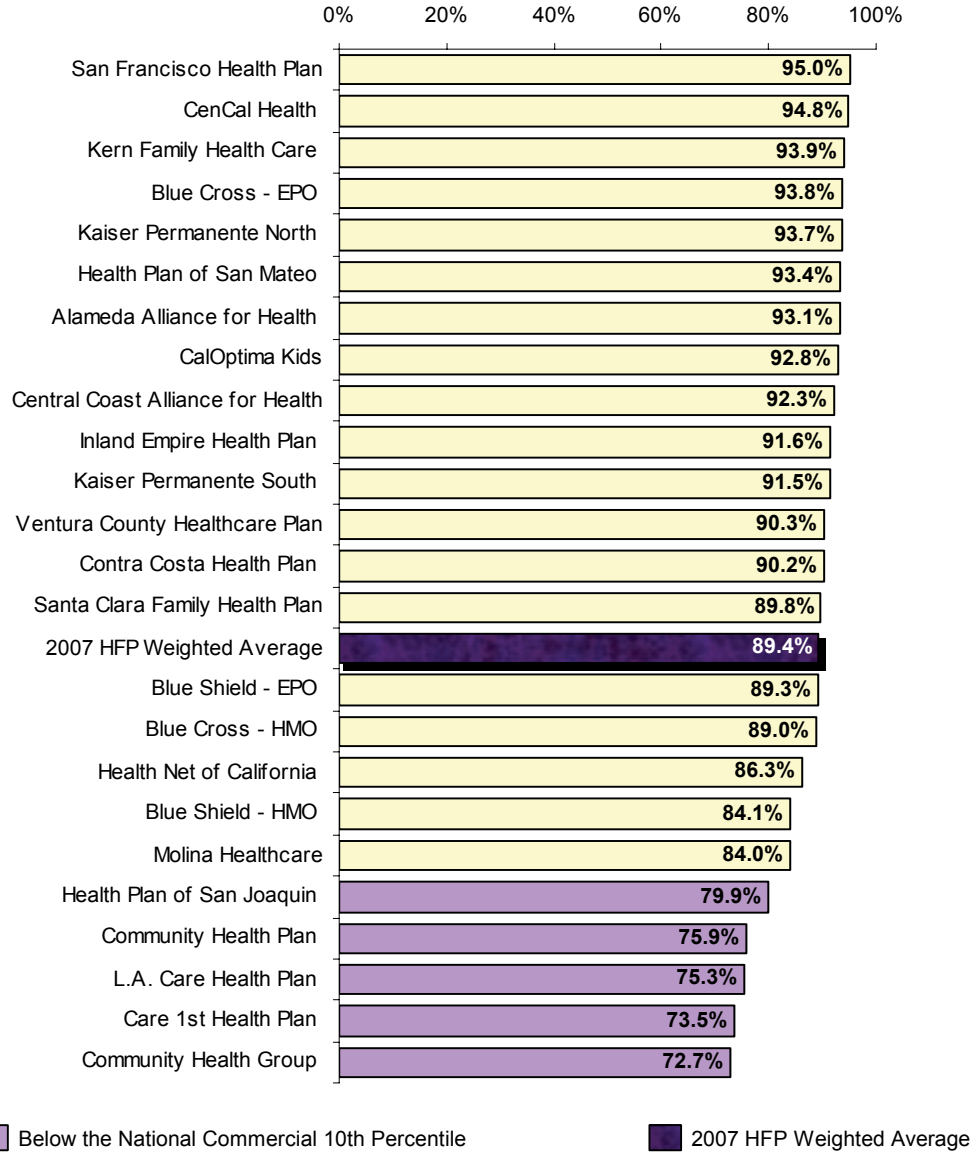


** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Children and Adolescents Access to Primary Care Practitioners, Ages 25 Months to 6 Years

The rates below represent the percentage of children ages 25 months to 6 years who had at least one visit with a PCP.

Figure 50. Individual Plan Rates for Children and Adolescents' Access to Primary Care Practitioners, Ages 25 Months - 6 Years



Health Plan Comparison

Individual plan rates ranged from 95% to 72.7%.

There were no health plans that had rates that were above the national Commercial 90th percentile (95.3%).

Five plans had rates that were below the national Commercial 10th percentile (83.5%):

- Health Plan of San Joaquin
- Community Health Plan
- L.A. Care Health Plan
- Care 1st Health Plan
- Community Health Group

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 51. Children and Adolescents' Access to PCP, Ages 25 Months to 6 Years by Spoken Language

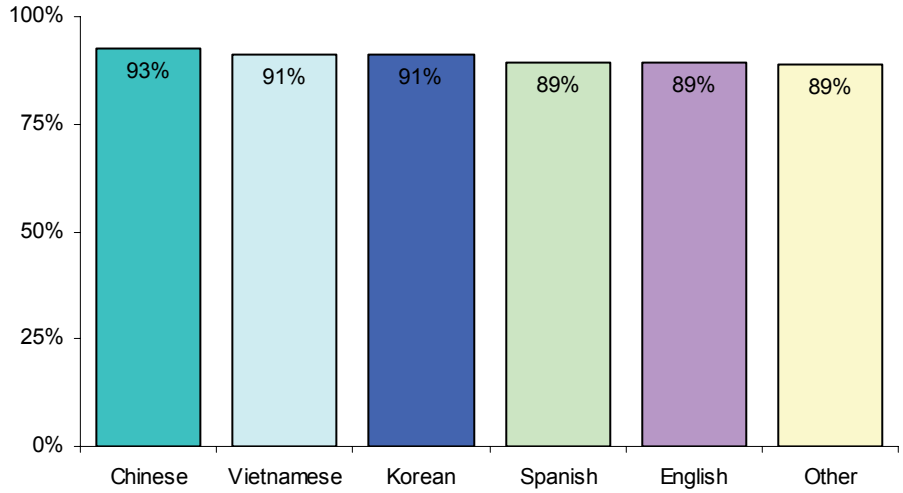
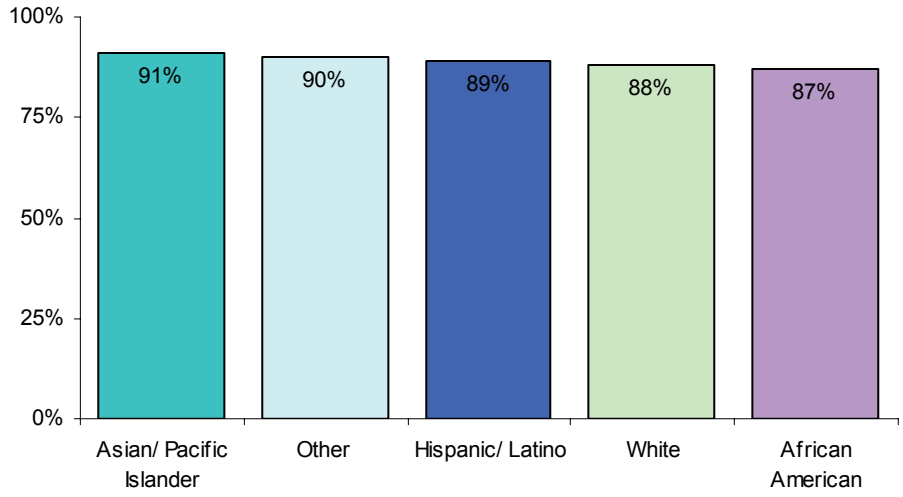


Figure 52. Children and Adolescents' Access to PCP, Ages 25 Months to 6 Years by Ethnicity



Key Findings About Demographics

- There are virtually no differences by ethnicity in the number of children ages 25 months to 6 years who had a visit with a PCP.
- There were slight differences by ethnicity. Asian/Pacific Islanders had the highest rate of PCP visits while African American children who had the lowest rate.

Figure 53. Children and Adolescents' Access to PCP, Ages 25 Months to 6 Years by Region

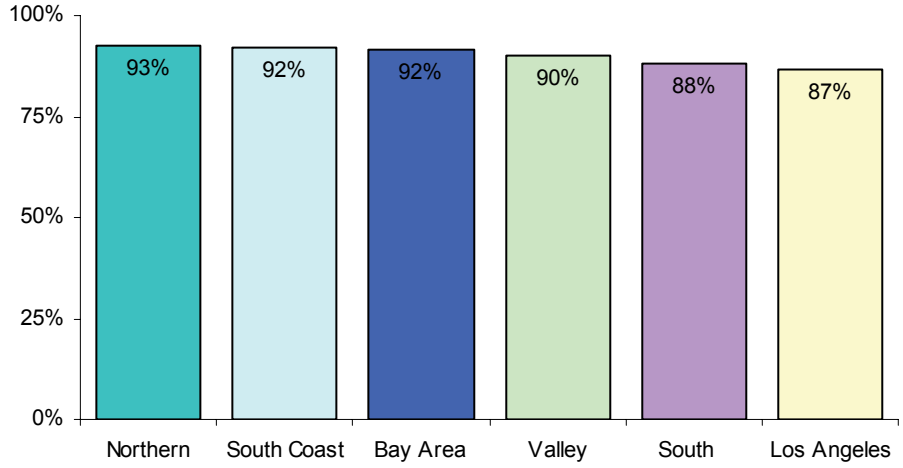


Figure 54. Children and Adolescents' Access to PCP, Ages 25 Months to 6 Years by FPL

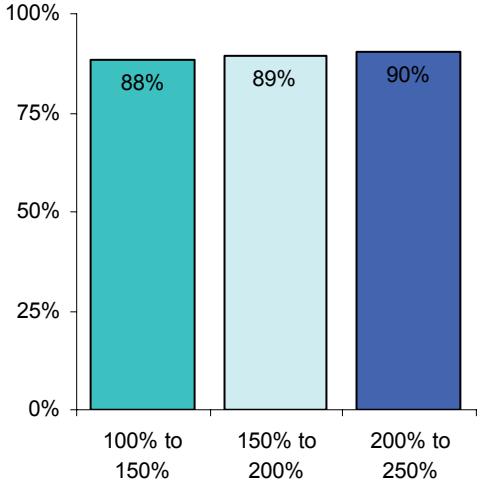
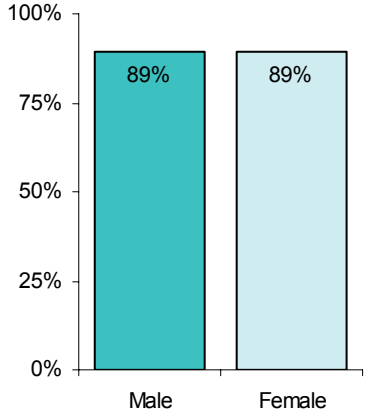


Figure 55. Children and Adolescents' Access to PCP, Ages 25 Months to 6 Years by Gender



Key Findings About Demographics

- Northern California had the highest rate while Los Angeles had the lowest.
- There were no significant differences by FPL or gender.

Children and Adolescents' Access to Primary Care Practitioners, Ages 7 to 11 Years

Measure Definition

The ***Children and Adolescents' Access to Primary Care Practitioner, Ages 7 to 11 Years*** measure assesses how many children ages 7 to 11 years had a visit with a primary care practitioner in 2006 or 2007.

Why Is This Important?

Doctor's visits provide an opportunity for the provider and the child to develop a relationship and an important opportunity to provide counseling on topics such as diet, exercise and risky behaviors. This measure also provides a convincing argument for the importance of health insurance. Without the Healthy Families Program, these children would have ended up in emergency rooms or gone untreated, resulting in missed days of school and poor health.

Results

Approximately 89% of children ages 7 to 11 years had a visit with a PCP during the measurement year. This rate exceeds the national Medicaid average and is comparable to the national Commercial averages.

Benchmarking and Trend Analysis

Comparisons to national benchmarks are presented in Figure 56 and trends for 2005 through 2007 are presented in Figure 57.

Figure 56. Comparison to National Benchmarks for Children's Access to PCP, 7 to 11 Years

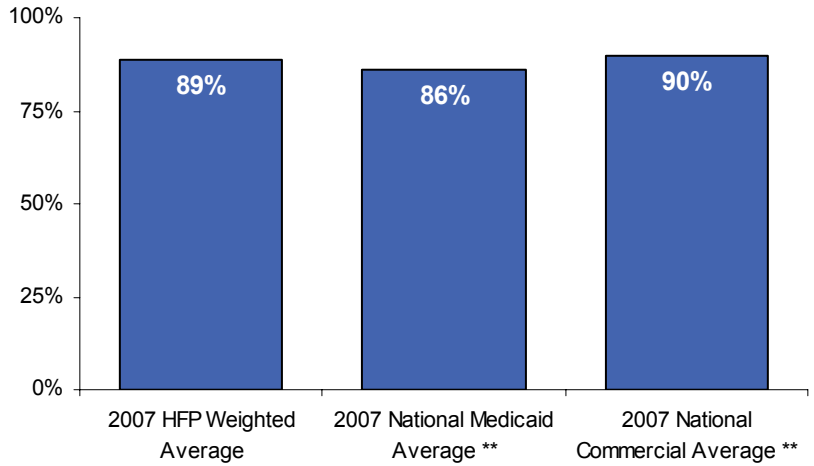
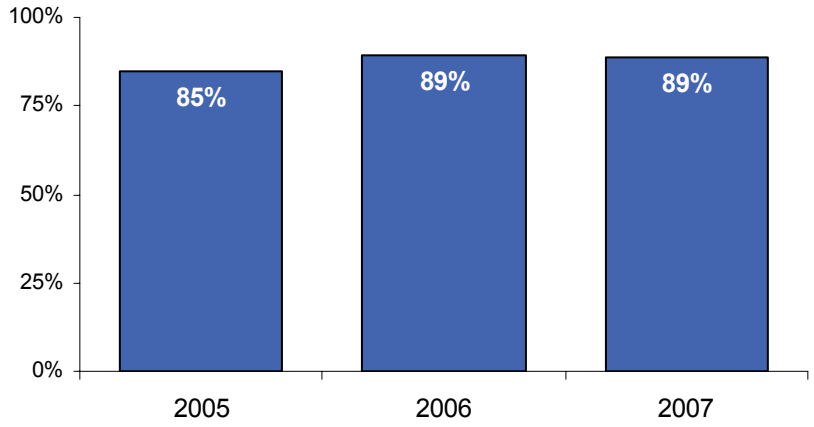


Figure 57. HFP 3 Year Trend for Children and Adolescents Access to PCP, Ages 7 to 11 Years

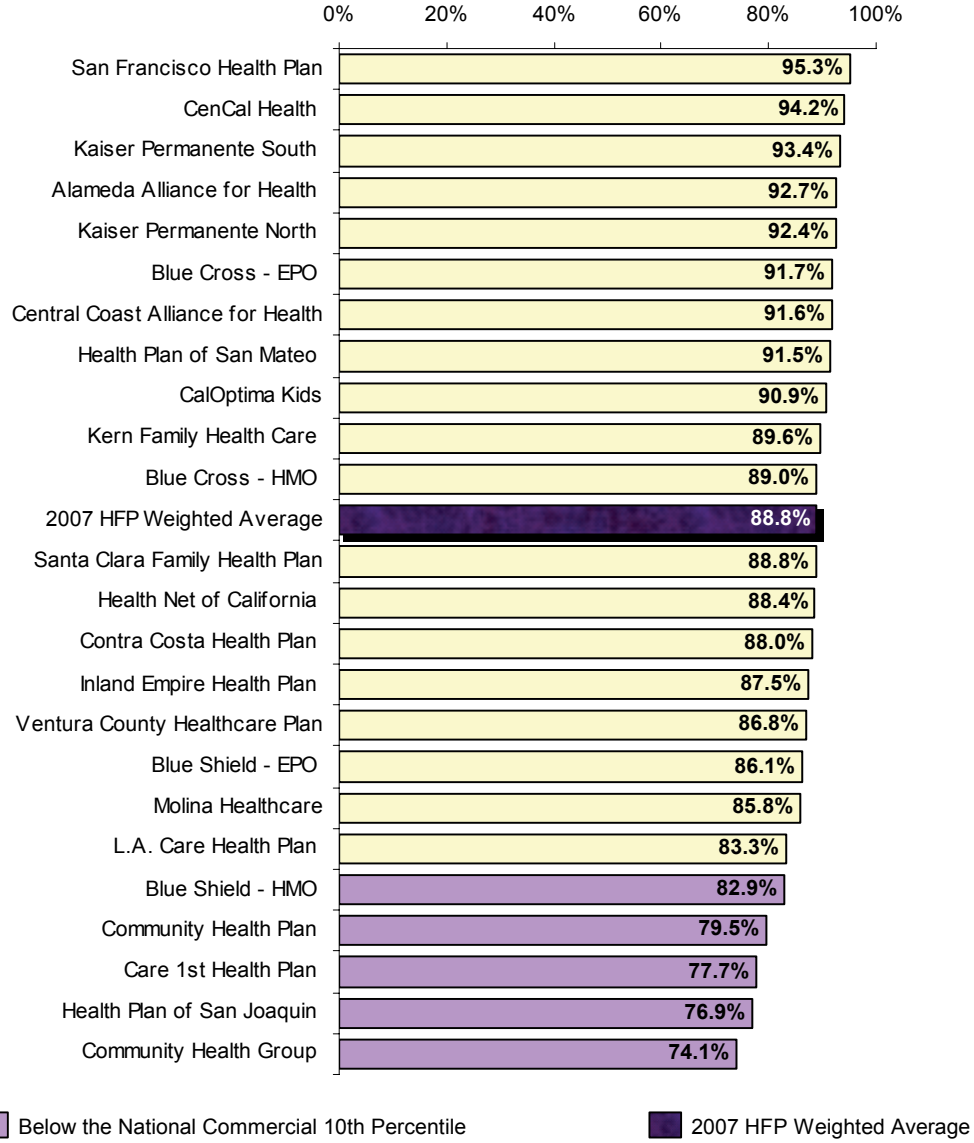


* ** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Children and Adolescents Access to Primary Care Practitioners, Ages 7 to 11 Years

The rates below represent the percentage of children ages 7 to 11 years who had at least one visit with a PCP.

Figure 58. Individual Plan Rates for Children and Adolescents' Access to Primary Care Practitioners, Ages 7 - 11 Years



Health Plan Comparison

Individual plan rates ranged from 95.3% to 74.1%.

There were no plans that had a rate that was above the national Commercial 90th percentile (96.3%).

Five plans had rates that were below the national Commercial 10th percentile (83%):

- Blue Shield - HMO
- Community Health Plan
- Care 1st Health Plan
- Health Plan of San Joaquin
- Community Health Group

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 59. Children and Adolescents' Access to PCP, Ages 7 to 11 Years by Spoken Language

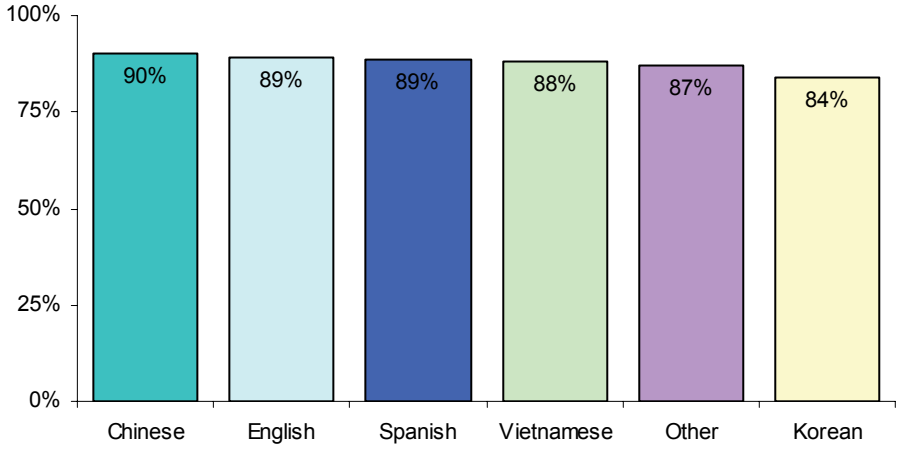
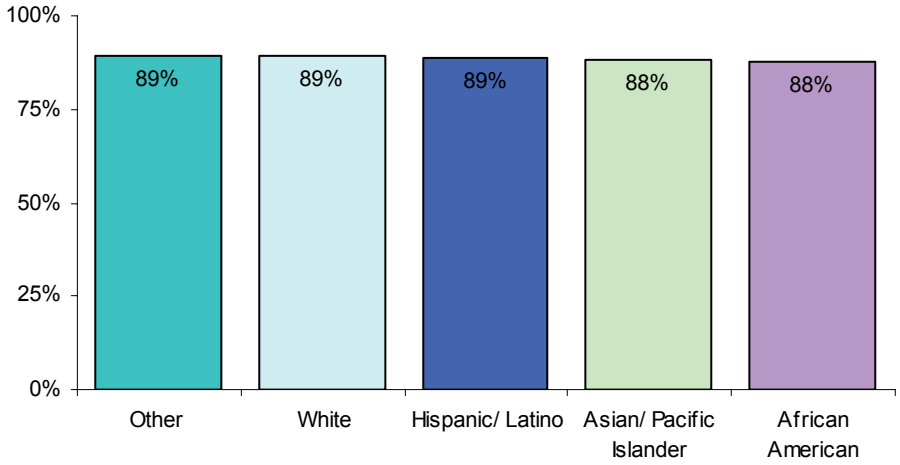


Figure 60. Children and Adolescents' Access to PCP, Ages 7 to 11 Years by Ethnicity



Key Findings About Demographics

- Korean children ages 7 to 11 years had a visit with a PCP at a slightly lower rate compared to other ethnicities.
- There was no significant difference in the number of children and adolescents who had a visit with a primary care practitioner by ethnicity.

Figure 61. Children and Adolescents' Access to PCP, Ages 7 to 11 Years by Region

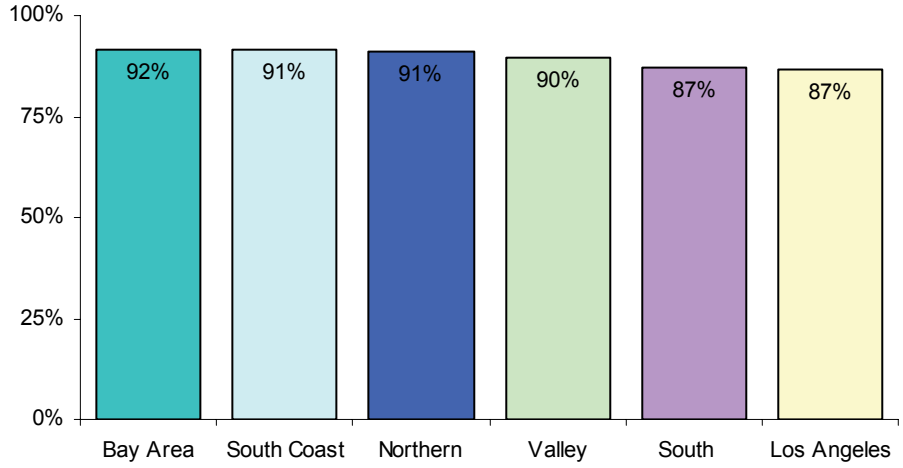


Figure 62. Children and Adolescents' Access to PCP, Ages 7 to 11 Years by FPL

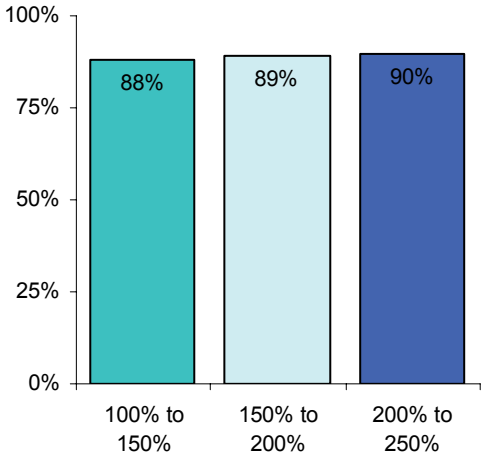
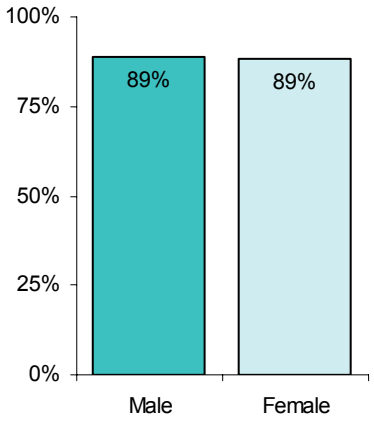


Figure 63. Children and Adolescents' Access to PCP, Ages 7 to 11 Years by Gender



Key Findings About Demographics

- Children ages 7 to 11 years in the Southern region and Los Angeles had a visit with a primary care practitioner at a slightly lower rate compared to other regions.
- There was no significant difference by FPL or gender.

Children and Adolescents' Access to Primary Care Practitioners, Ages 12 to 18 Years

Measure Definition

The ***Children and Adolescents' Access to Primary Care Practitioner, Ages 12 to 18 Years*** measure assesses how many children ages 12 to 18 years had a visit with a primary care practitioner in 2006 or 2007.

Why Is This Important?

Doctor's visits provide an opportunity for the provider and the child to develop a relationship. This is also an important opportunity, particularly for the adolescent population, for doctors to provide counseling on topics such as diet, exercise and risky behaviors.

The results of the Young Adult Health Care Survey (YAHCS) showed that teens receive counseling and screening for risky behaviors at a very low rate. However, teens who had a routine care visit in the last 12 months reported slightly higher rates of counseling and screening for risky behaviors and higher overall satisfaction with the program. Visits to a PCP, as assessed by this measure, offer an important opportunity for counseling and screening for risky behaviors and improving the overall health of the adolescent population.

Results

Approximately 86% of children ages 12 to 18 years had a visit with a PCP during the measurement year. While less than half of adolescents received a well-care visit with a PCP or OB/GYN, the results of this measure indicate that adolescents are still receiving care when they need it. This rate exceeds the national Medicaid average and is comparable to the national Commercial averages.

Benchmarking and Trend Analysis

Comparisons to national benchmarks are presented in Figure 64 and trends for 2005 through 2007 are presented in Figure 65.

Figure 64. Comparison to National Benchmarks for Adolescents Access to PCP, Ages 12 to 18 Years

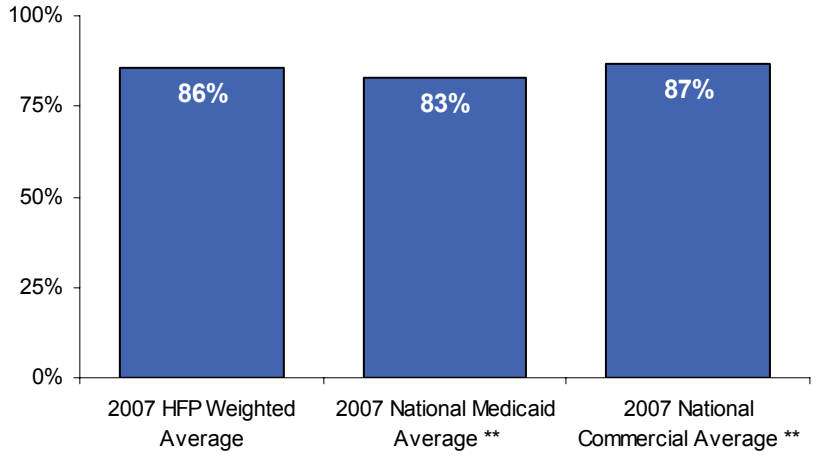
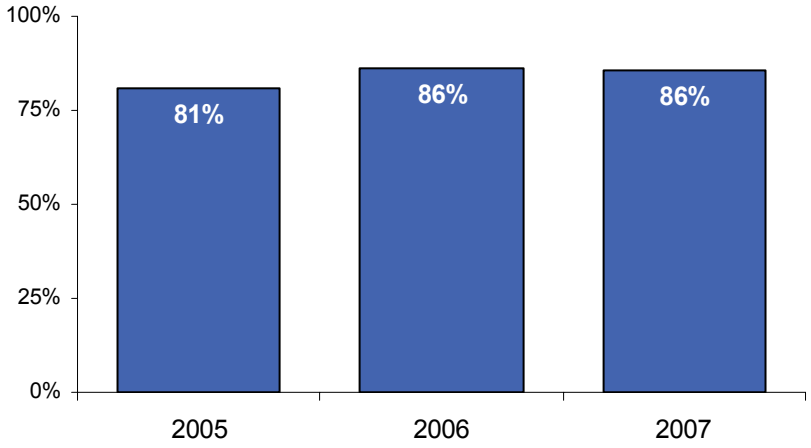


Figure 65. HFP 3 Year Trend for Children and Adolescents Access to PCP, Ages 12 to 18 Years

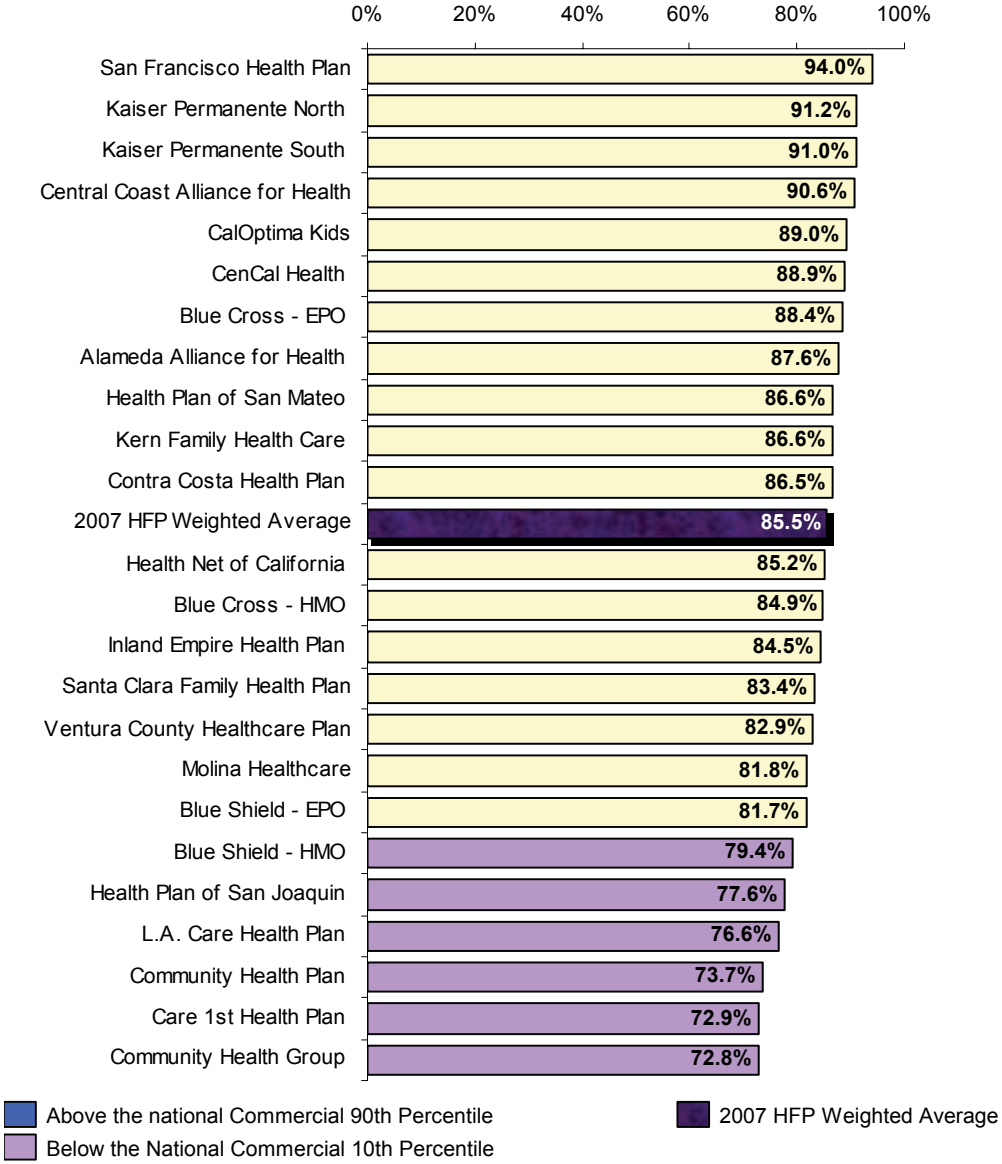


** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Children and Adolescents' Access to Primary Care Practitioners, Ages 12 to 18 Years

The rates below represent the percentage of children ages 12 to 18 years who had at least one visit with a PCP.

Figure 66. Individual Plan Rates for Children and Adolescents' Access to Primary Care Practitioners, Ages 12 to 18 Years



Health Plan Comparison

Individual plan rates ranged from 94% to 72.8%.

No health plans had a rate that was above the national Commercial 90th percentile (94.1%).

Six plans had rates that were below the national Commercial 10th percentile (80.5%):

- Blue Shield - HMO
- Health Plan of San Joaquin
- L.A. Care Health Plan
- Community Health Plan
- Care 1st Health Plan
- Community Health Group

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 67. Children and Adolescents' Access to PCP, Ages 12 to 18 Years by Spoken Language

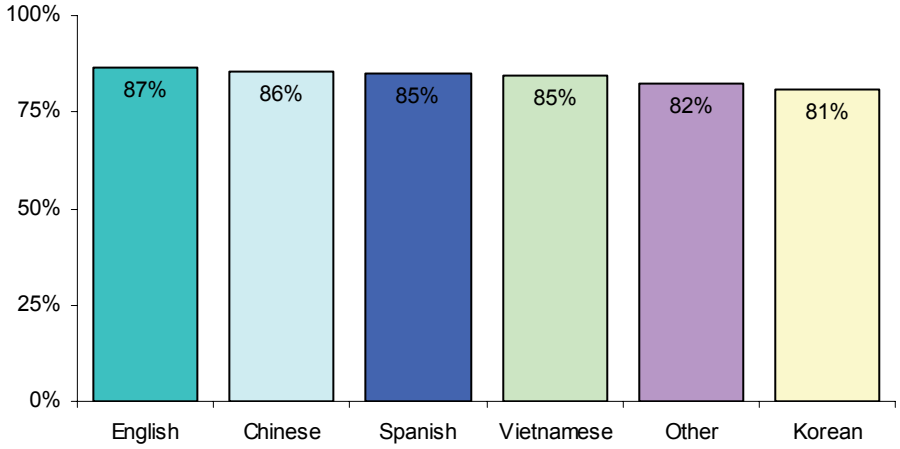
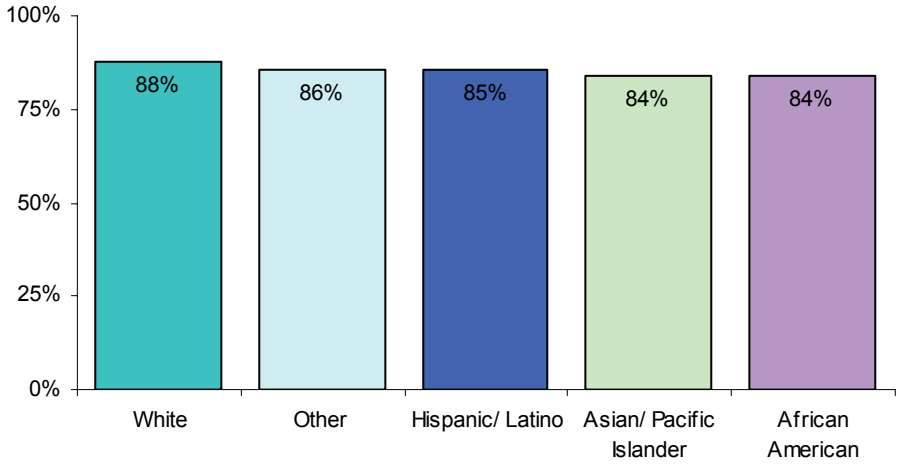


Figure 68. Children and Adolescents' Access to PCP, Ages 12 to 18 Years by Ethnicity



Key Findings About Demographics

- Korean and Other language speakers ages 12 to 18 years had a visit with a PCP at the lowest rate.
- African American and Asian/Pacific Islander adolescents had a slightly lower rate of visits with a PCP compared to Whites.

Figure 69. Children and Adolescents' Access to PCP, Ages 12 to 18 Years by Region

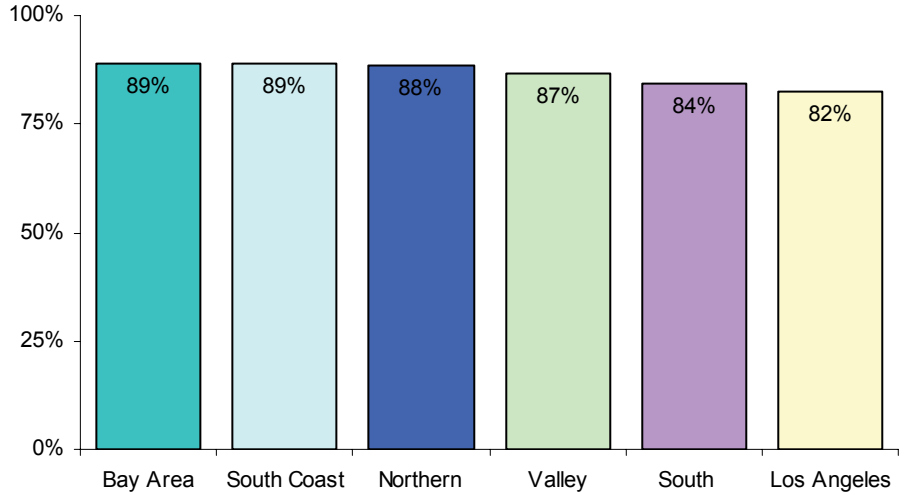


Figure 70. Children and Adolescents' Access to PCP, Ages 12 to 18 Years by FPL

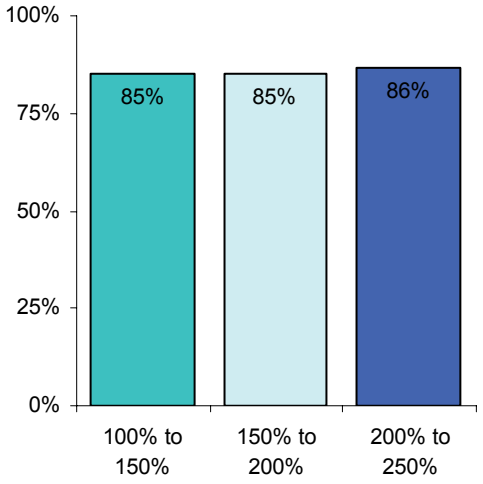
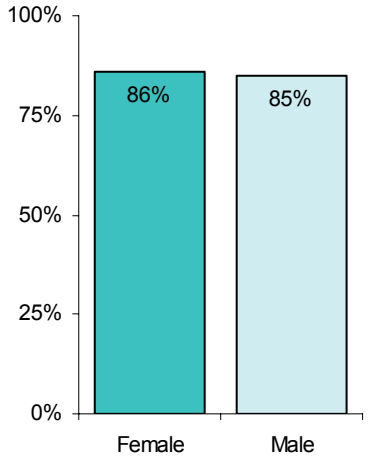


Figure 71. Children and Adolescents' Access to PCP, Ages 12 to 18 Years by Gender



Key Findings About Demographics

- Adolescents in Los Angeles had the lowest rate compared to teens in other regions.
- Rates were essentially the same among adolescents with different family household incomes and for males and females.

Use of Appropriate Medications for People with Asthma

Measure Definition

The ***Use of Appropriate Medications for People with Asthma*** measure assesses the number of children ages 5 to 18 years who were identified as having persistent asthma, and received a medication that is considered appropriate for the long-term control of asthma.

Why Is This Important?

"Asthma is the most common chronic childhood disease, affecting an estimated 5 million children...Successful management of asthma can be achieved for most asthmatics if they take medications that provide long-term control."[11] "Asthma is the leading cause of school absenteeism attributed to chronic conditions and is the third-leading cause of hospitalization among children under the age of 15." [12]

Results

Ninety-four percent (94%) of HFP children with persistent asthma received the appropriate mediation for the long-term control of asthma. This exceeds both the state Medi-Cal Managed Care average and the national Medicaid average and is close to the national Commercial average. The rate is the same as what was reported in 2006.

Another notable finding was that there were nearly twice as many males (4,345) with persistent asthma than females (2,470).

This is the first year HFP plans reported this measure.

Benchmarking and Trend Analysis

Comparisons to state and national benchmarks are presented in Figure 72. The HFP weighted average for calendar years 2005 through 2007 are presented in Figure 73.

Figure 72. Comparison to State and National Benchmarks Use of Appropriate Medications for People with Asthma

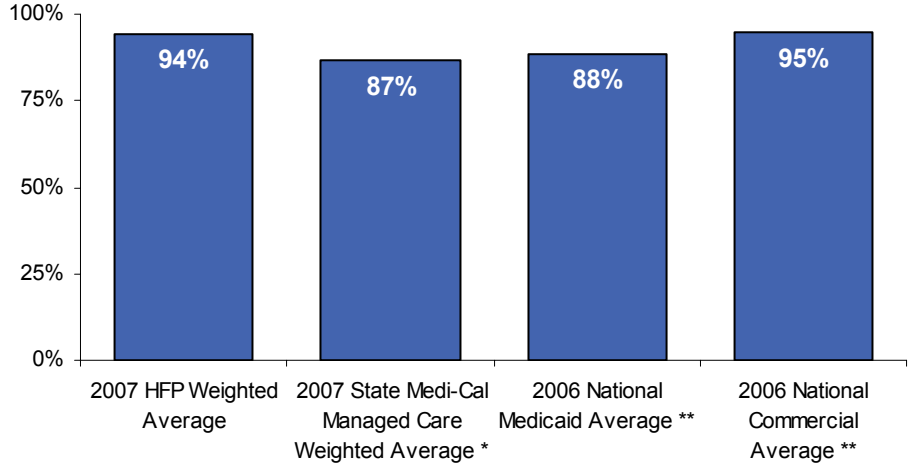
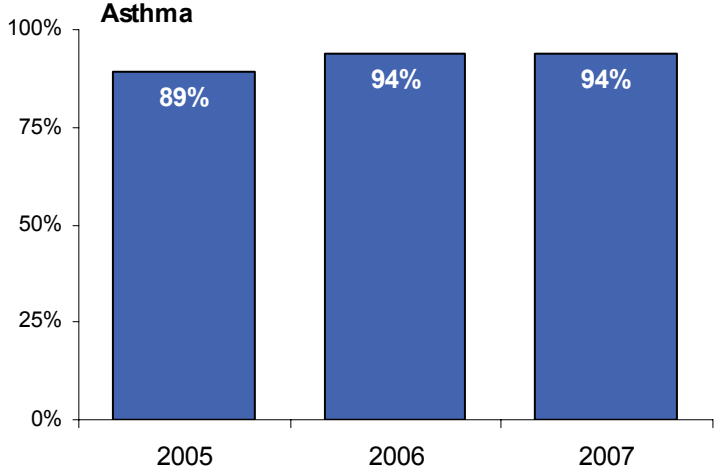


Figure 73. HFP 3 Year Trend for Use of Appropiate Medications for People with Asthma



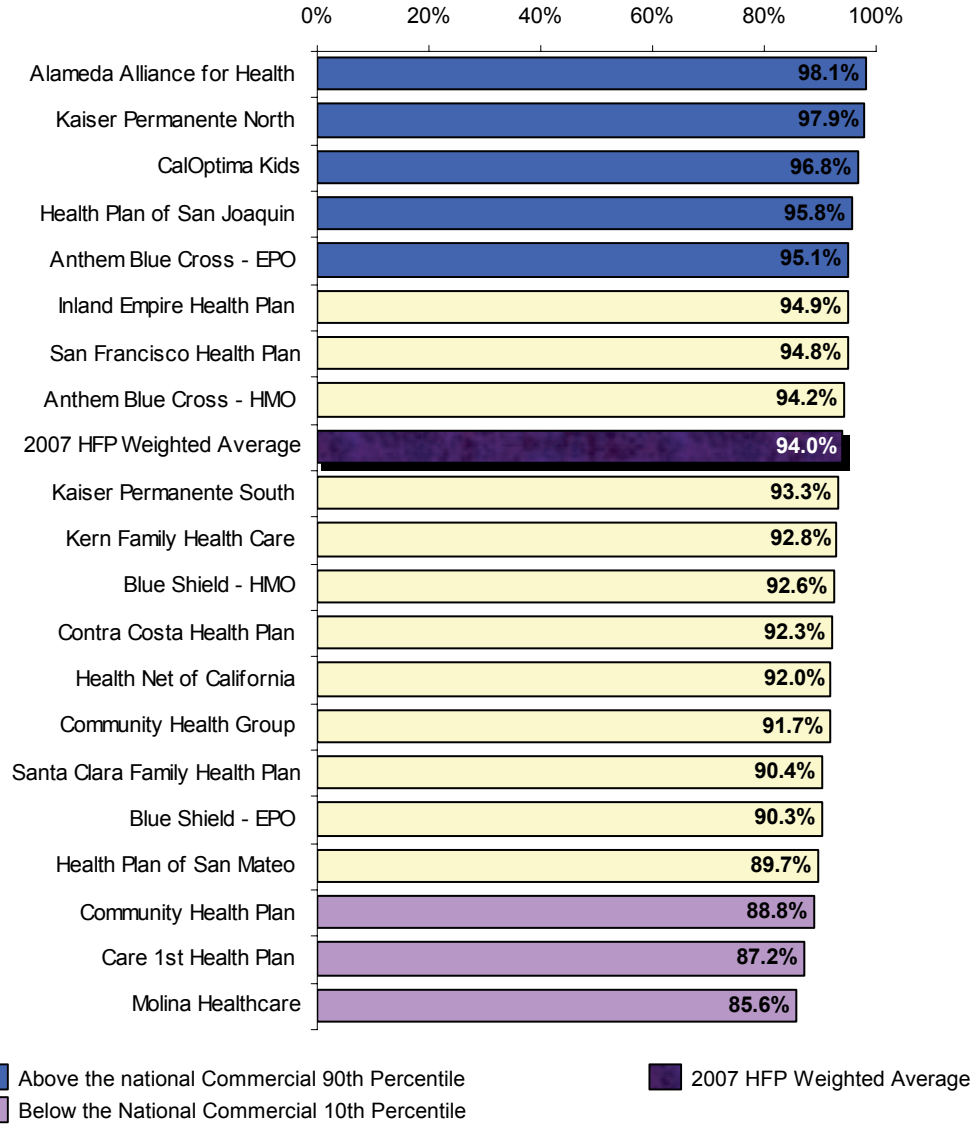
11 NCQA's HEDIS® 2009, Volume 1: Narrative
12 NCQA's The State of Health Care Quality 2008

* Rate obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*
** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Use of Appropriate Medications for People with Asthma

The rates below represent the percentage of children ages 5 to 18 years who were identified as having persistent asthma, and received a medication that is considered appropriate for the long-term control of asthma.

Figure 74. Individual Plan Scores for Use of Appropriate Medications for People with Asthma, All Ages



Health Plan Comparison

There was minimal variation in individual plan rates with rates ranging from 98.1% to 85.6%.

Five health plans had rates that were at or above the national Commercial 90th percentile (95.1%):

- Alameda Alliance for Health
- Kaiser Permanente North
- CalOptima Kids
- Health Plan of San Joaquin
- Anthem Blue Cross - EPO

Three health plans had rates that were below the national Commercial 10th percentile (88.9%):

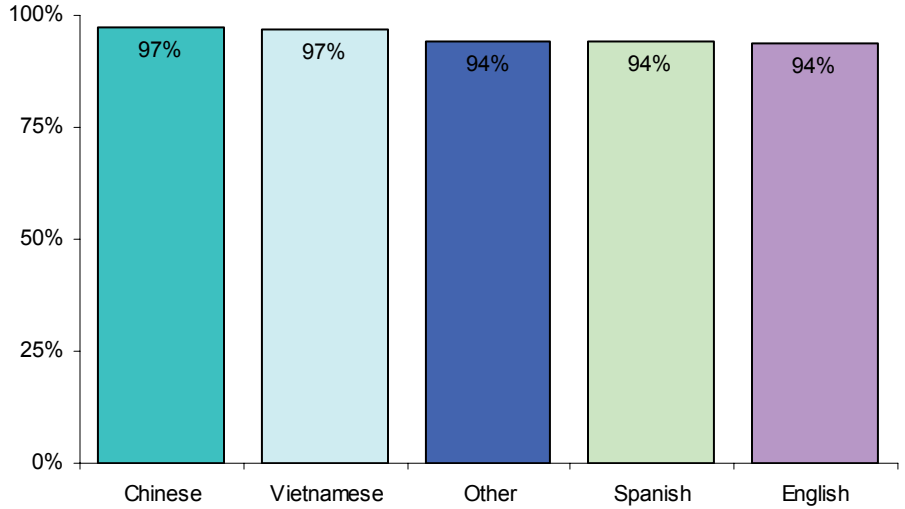
- Community Health Plan
- Care 1st Health Plan
- Molina Healthcare

The following plans had an eligible population of less than 30 and were not included in the analysis:

- CenCal Health
- Central Coast Alliance for Health
- Ventura County Health Plan

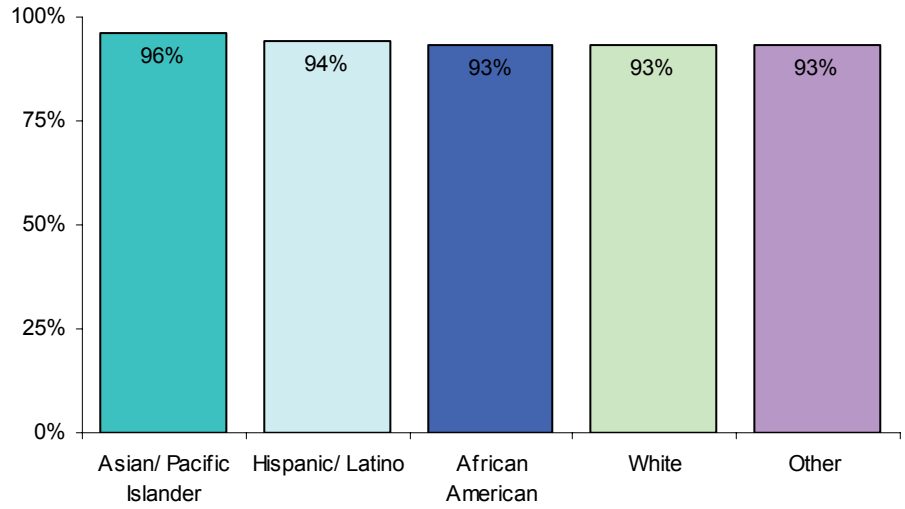
Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 75. Use of Appropriate Medications for People with Asthma by Spoken Language



Note: There were less than 30 eligible Korean speakers, therefore they were not included in the analysis.

Figure 76. Use of Appropriate Medications for People with Asthma by Ethnicity



Key Findings About Demographics

- There were no significant differences in the number of children that received appropriate asthma medication by spoken language or ethnicity.

Use of Appropriate Medications for People with Asthma

Figure 77. Use of Appropriate Medications for People with Asthma by Region

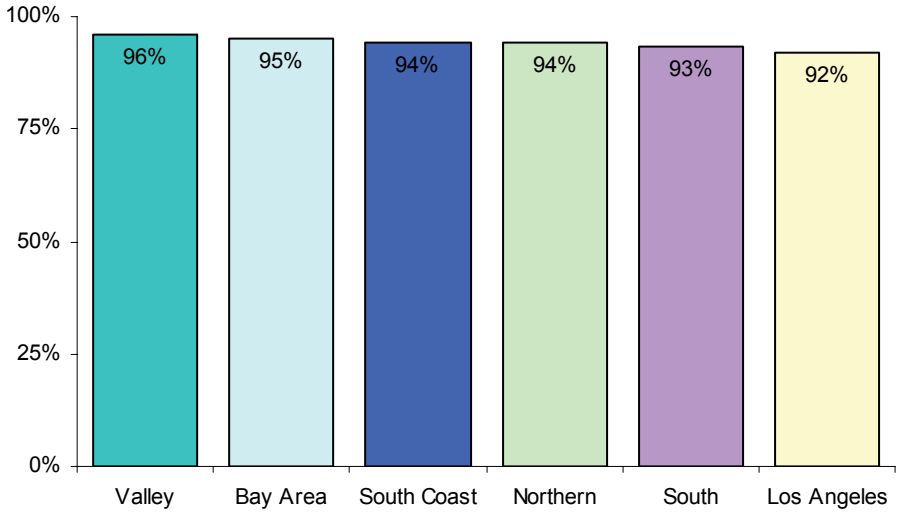


Figure 78. Use of Appropriate Medications for People with Asthma by FPL

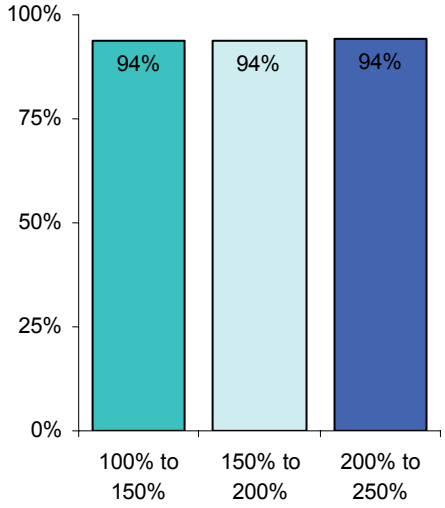
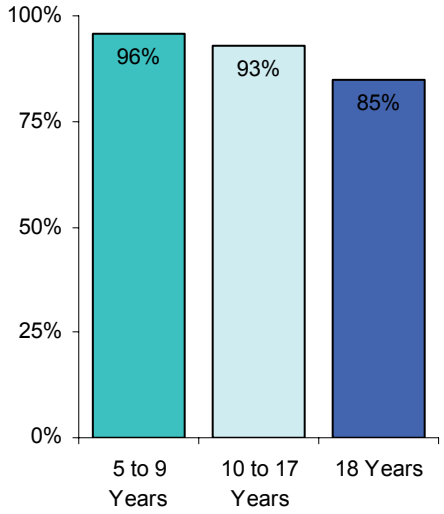


Figure 79. Use of Appropriate Medications for People with Asthma by Age Group



Key Findings About Demographics

- The Valley region had the highest rate of children that received appropriate asthma medication and Los Angeles had the lowest rate.
- Younger children were significantly more likely to have received appropriate asthma medication than older children and adolescents.

Use of Appropriate Medications for Children with Upper Respiratory Infections

Measure Definition

The ***Use of Appropriate Medications for Children with Upper Respiratory Infections*** measure assesses how many children ages 3 months to 18 years who had an upper respiratory infection (common cold) and were not prescribed an antibiotic.

Why Is This Important?

"Each year, Americans suffer an estimated one billion upper respiratory infections, known as the common cold. Colds are especially prevalent among children, owing to their lack of exposure to prior colds and their high contact with other children. Children have an estimated three to eight colds a year. The common cold is most often viral; accordingly, existing clinical guidelines do not support the use of antibiotics. Nevertheless, antibiotics are frequently prescribed in children with upper respiratory infections." [13]

Results

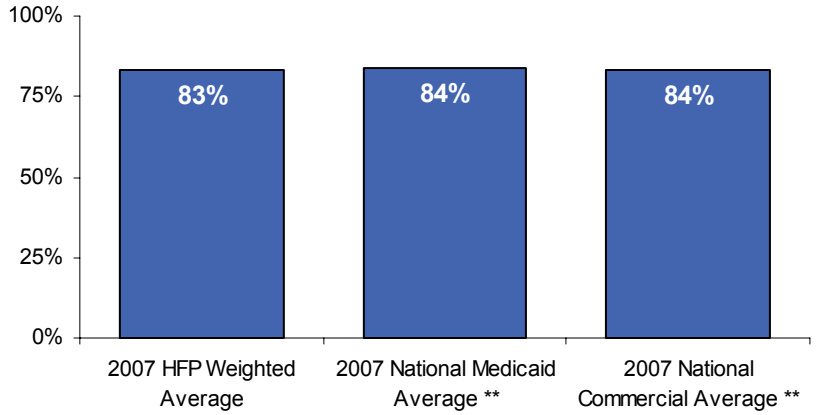
Eighty-three (83%) of HFP children received the appropriate treatment for an upper respiratory infection. This is essentially the same as the national Medicaid average and the national Commercial average.

This is the first year HFP plans reported this measure.

Benchmarking and Trend Analysis

Comparisons to national benchmarks are presented in Figure 80. This is the first year the HFP has collected data for this measure, therefore, no trend data is available.

Figure 80. Comparison to National Benchmarks Appropriate Treatment for Children with Upper Respiratory Infections



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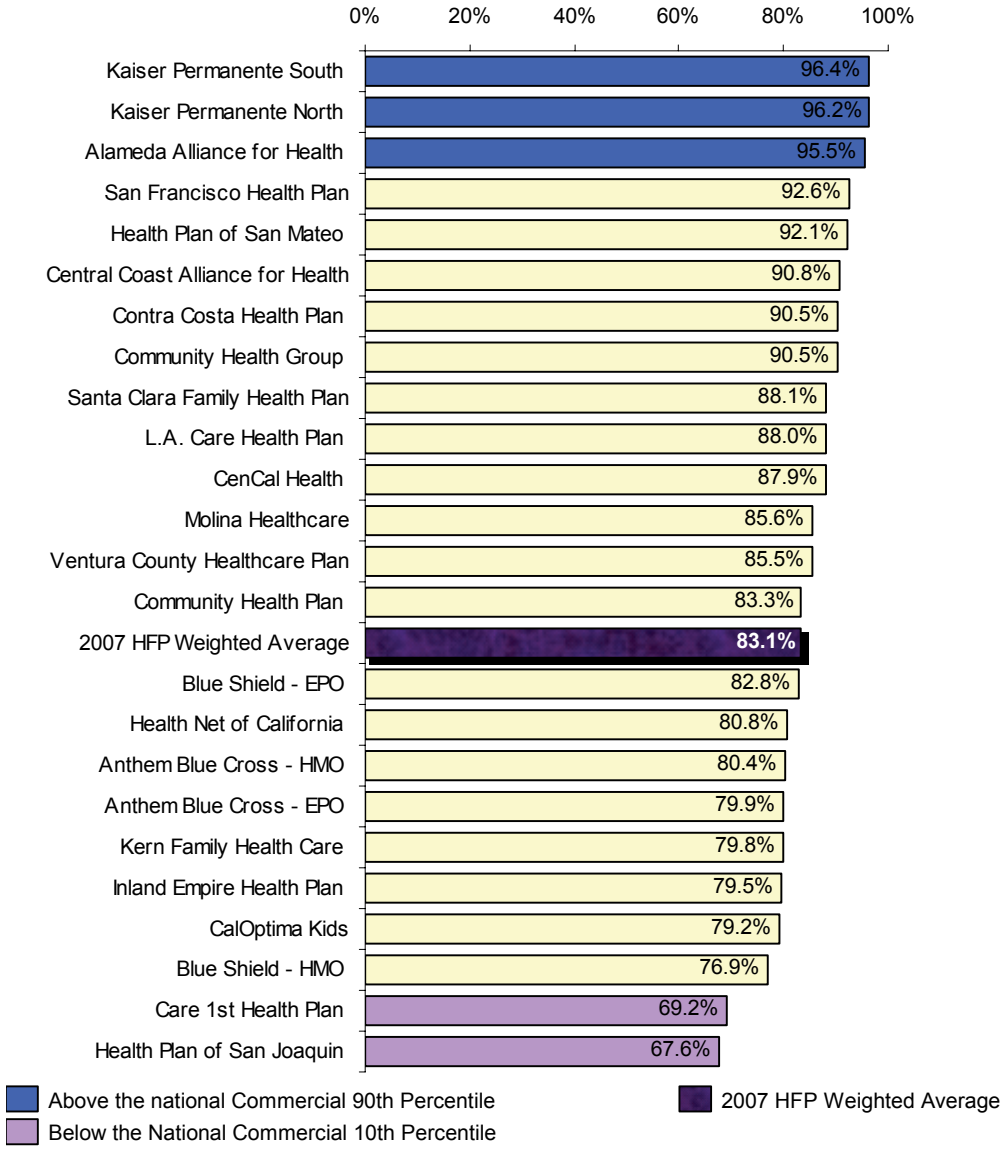
** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Use of Appropriate Medications for Children with Upper Respiratory Infections

The rates below represent the percentage of children ages 3 months to 18 years who received a diagnoses of upper respiratory infection and were not prescribed an antibiotic.

Figure 81. Individual Plan Rates for Appropriate Treatment for Children with Upper Respiratory Infection



Health Plan Comparison

Individual plan rates ranged from 96.4% to 67.6%.

Three health plans had rates that were above the national Commercial 90th percentile (92.8%):

- Kaiser Permanente South
- Kaiser Permanente North
- Alameda Alliance for Health

Two health plans had rates that were below the national Commercial 10th percentile (74.5%):

- Care 1st Health Plan
- Health Plan of San Joaquin

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 82. Appropriate Treatment for Children with Upper Respiratory Infections by Spoken Language

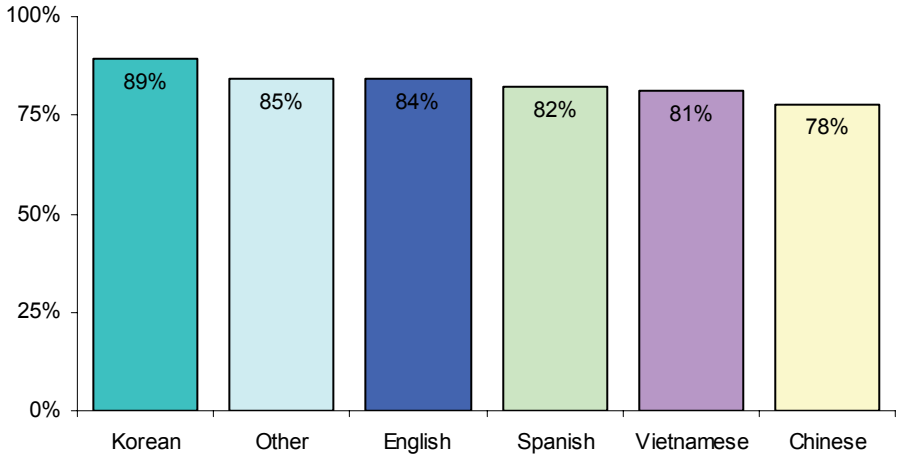
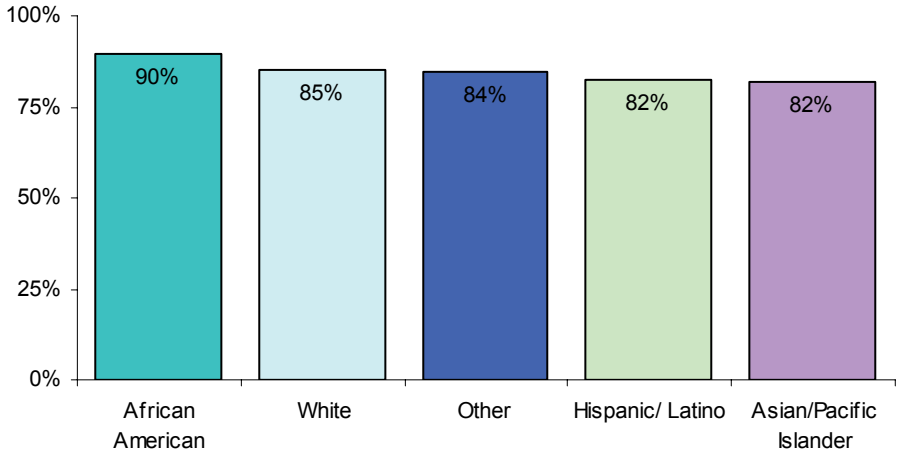


Figure 83. Appropriate Treatment for Children with Upper Respiratory Infections by Ethnicity



Key Findings About Demographics

- There were some differences in the number of children that received appropriate treatment for an upper respiratory infection based on the spoken language. Korean speakers were the most likely to have received appropriate treatment and Chinese speakers were the least likely.
- African American children received the appropriate treatment at higher rates than all other ethnic groups. Asian/ Pacific Islander and Latino children had the lowest rates.

Figure 84. Appropriate Treatment for Children with Upper Respiratory Infections by Region

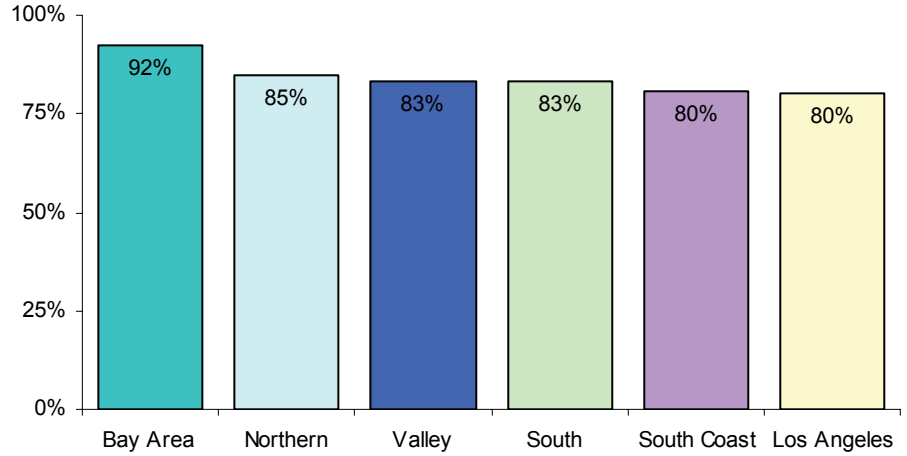


Figure 85. Appropriate Treatment for Children with Upper Respiratory Infections by FPL

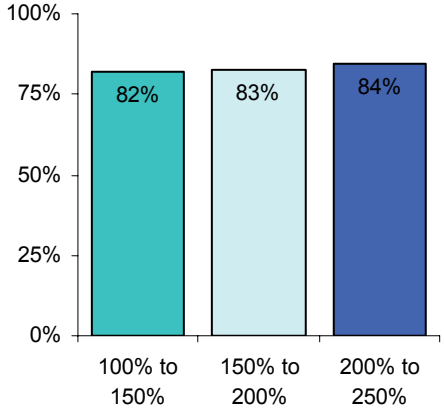
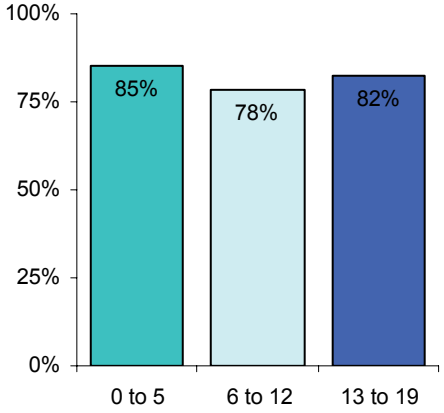


Figure 86. Appropriate Treatment for Children with Upper Respiratory Infections by Age Group



Key Findings About Demographics

- Children in the Bay Area received appropriate treatment for upper respiratory infections at a significantly higher rate than children in all other regions. The South Coast region and Los Angeles had the lowest rates of appropriate treatment.
- There was no significant difference based on FPL in the number of children who received appropriate medication for upper respiratory infections.
- Children ages 6 to 12 years old were the least likely to have received appropriate treatment for upper respiratory infections.

Appropriate Testing for Children with Pharyngitis

Measure Definition

The ***Appropriate Testing for Children with Pharyngitis*** measure assesses how many children ages 2 to 18 years old were diagnosed with pharyngitis (or sore throat) and received a Group A streptococcus test prior to being dispensed an antibiotic.

Why Is This Important?

"Pharyngitis (or sore throat) is most commonly caused by viruses. While antibiotics are needed to treat bacterial pharyngitis, they are not useful for treating viral pharyngitis. Only 25 to 50 percent of sore throat cases in children are caused by Group A streptococcus bacteria, more commonly referred to as strep throat. Before antibiotics are prescribed, a simple diagnostic test is necessary to validate bacterial origin of a sore throat. Unfortunately, a diagnostic test is not always performed before antibiotics are prescribed." [14]

Results

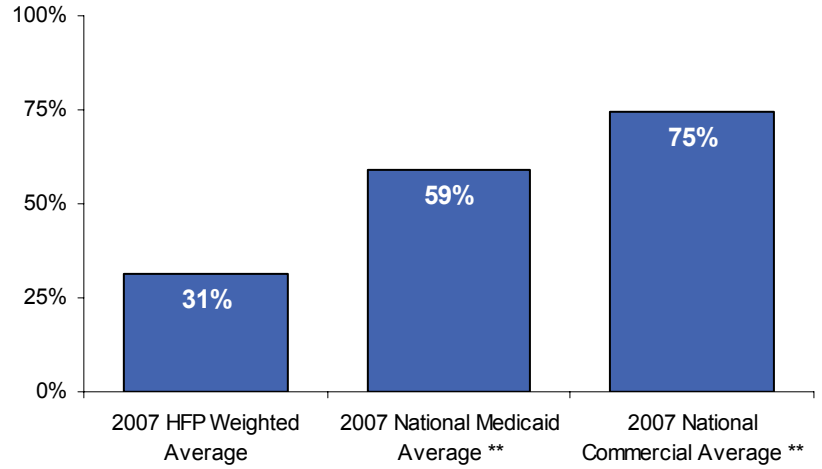
Thirty-one percent (31%) of HFP children received the appropriate testing for pharyngitis. This is well below the national Medicaid and Commercial averages.

This is the first year HFP plans reported this measure.

Benchmarking and Trend Analysis

Comparisons to national benchmarks are presented in Figure 87. This is the first year the HFP has collected data for this measure, therefore, no trend data is available.

Figure 87. Comparison to National Benchmarks
Appropriate Testing for Children with Pharyngitis

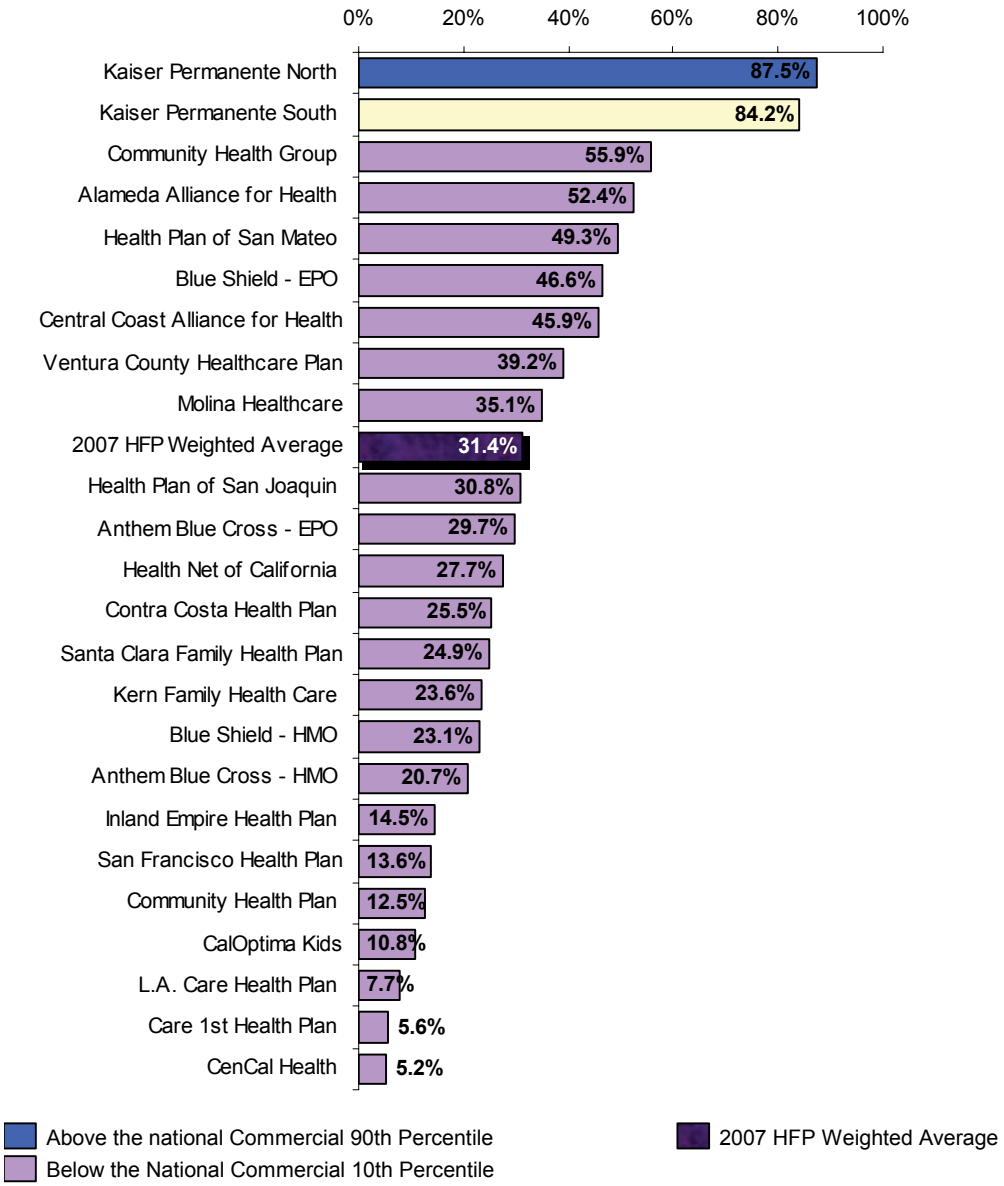


** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Appropriate Testing for Children with Pharyngitis

The rates below represent the percentage of children ages 2 to 18 years who were diagnosed with pharyngitis and received the appropriate testing.

Figure 88. Individual Plan Rates for Appropriate Testing for Children with Pharyngitis



Health Plan Comparison

Individual plan rates varied considerably with rates ranging from 87.5% to 5.2%.

Kaiser Permanente North had a rate that was above the national Commercial 90th percentile (87.5%).

With the exception of Kaiser Permanente South, the rates for all other health plans and the HFP average were well below the national Commercial 10th percentile (60.2%)

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 89. Appropriate Testing for Children with Pharyngitis by Spoken Language

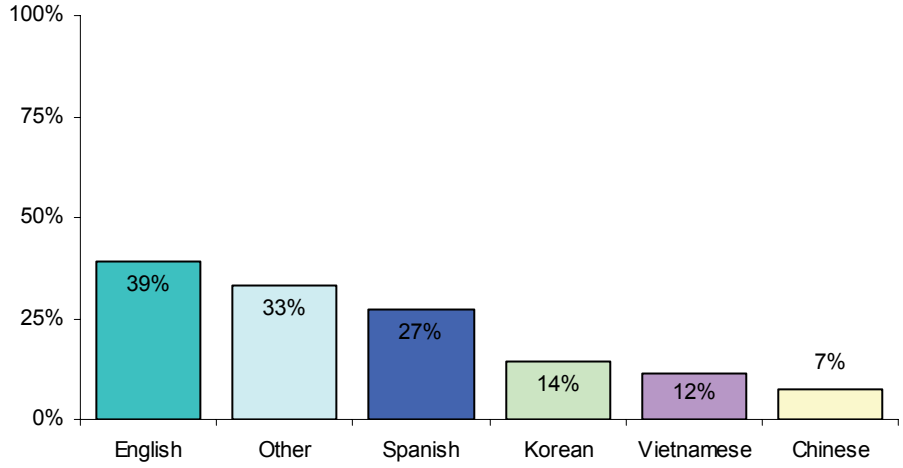
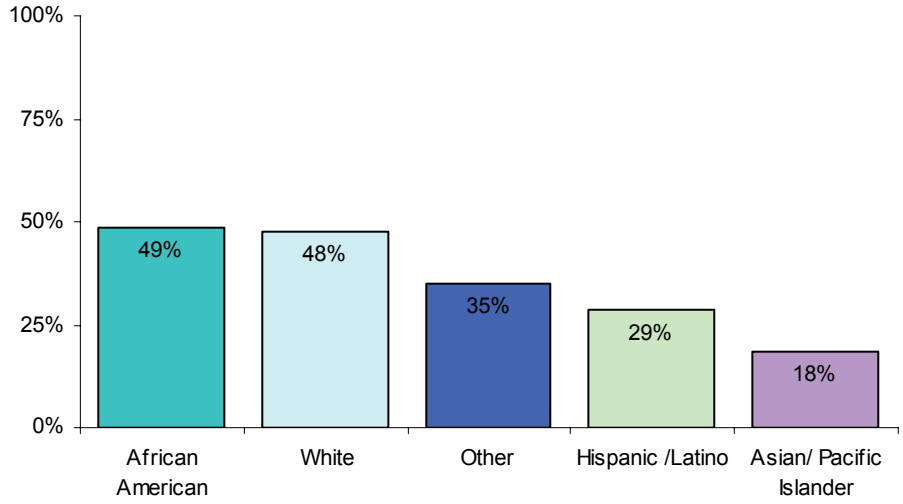


Figure 90. Appropriate Testing for Children with Pharyngitis by Ethnicity



Key Findings About Demographics

- Unlike other measures, Asian language speakers received appropriate testing for pharyngitis at significantly lower rates compared to English and Other language speakers.
- Nearly half of African American and White children received appropriate testing for pharyngitis compared to less than one-third of Hispanic/Latino children and less than one in five Asian/Pacific Islander children.

Appropriate Testing for Children with Pharyngitis

Figure 91. Appropriate Testing for Children with Pharyngitis by Region

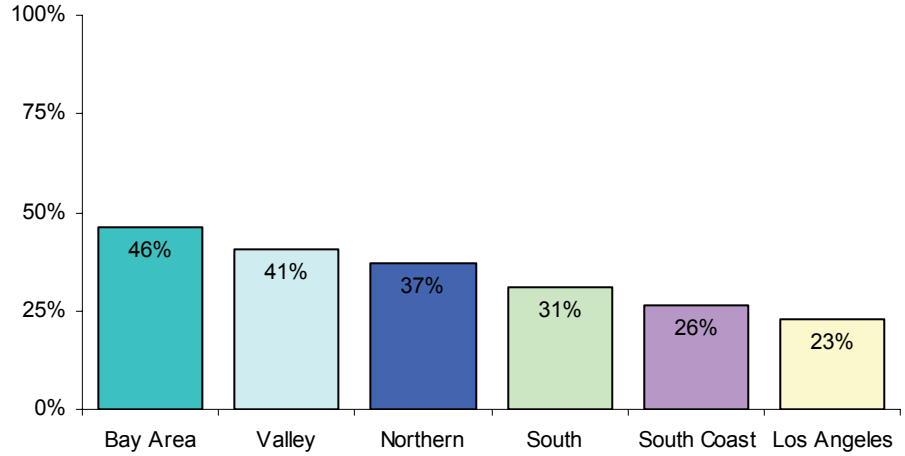


Figure 92. Appropriate Testing for Children with Pharyngitis by FPL

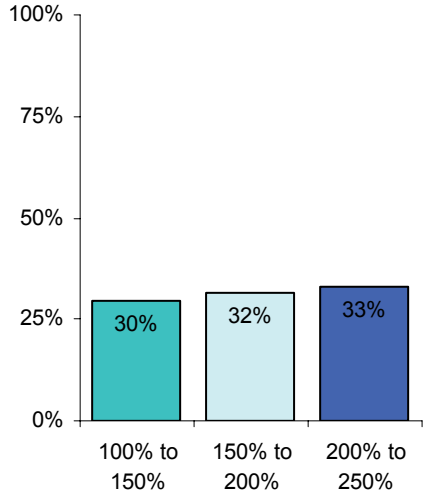
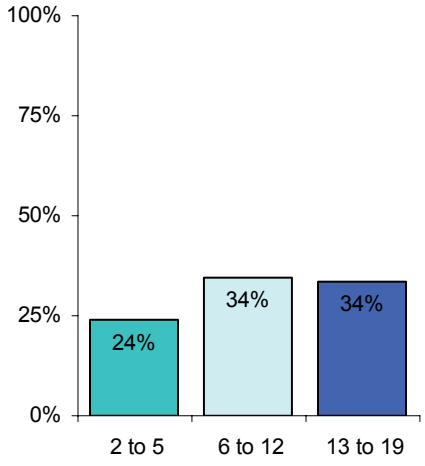


Figure 93. Appropriate Testing for Children with Pharyngitis by Age Group



Key Findings About Demographics

- Children in the Bay Area were twice as likely to have received appropriate testing for pharyngitis as children in Los Angeles.
- Southern California regions (South, South Coast and Los Angeles) had the lowest rates of appropriate testing.
- There was no significant difference by FPL.
- The youngest children, ages 2 to 5 years, were the least likely to have received appropriate testing for pharyngitis.

Chlamydia Screening

Measure Definition

The ***Chlamydia Screening*** measure assesses how many sexually active young women ages 16 to 18 years old were screened for Chlamydia.

Why Is This Important?

Chlamydia is the most common bacterial sexually transmitted disease in the United States with approximately 3 million new cases each year. If left untreated, Chlamydia infection can lead to pelvic inflammatory disease, infertility or ectopic pregnancy.[15] The U.S Preventive Services Task Force (USPSTF) recommends that sexually active women under the age of 24 should be tested annually for Chlamydia. Screening is important because the majority of women with Chlamydia do not experience any symptoms.[16]

Results

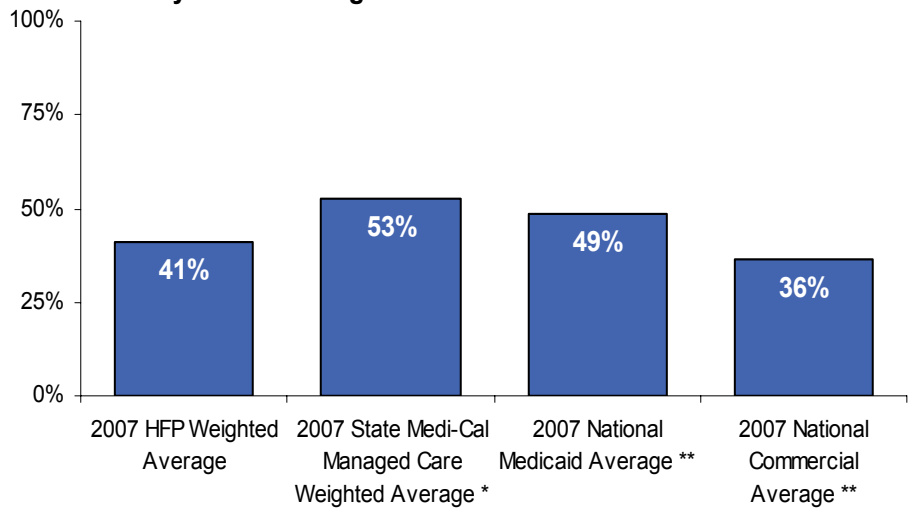
Forty-one (41%) of sexually active young women in HFP were screened for Chlamydia. This is significantly lower than both the state Medi-Cal weighted average and the national Medicaid average. However, it exceeds the national Commercial average.

This is the first year HFP plans reported this measure.

Benchmarking and Trend Analysis

Comparisons to national benchmarks are presented in Figure X. This is the first year the HFP has collected data for this measure, therefore, no trend data is available.

Figure 94. Comparison to State and National Benchmarks
Chlamydia Screening



15 NCQA's HEDIS® 2009, Volume 1: Narrative

16 U.S. Preventive Services Task Force. Screening for Chlamydia infection: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med 2007, 147: 128-33

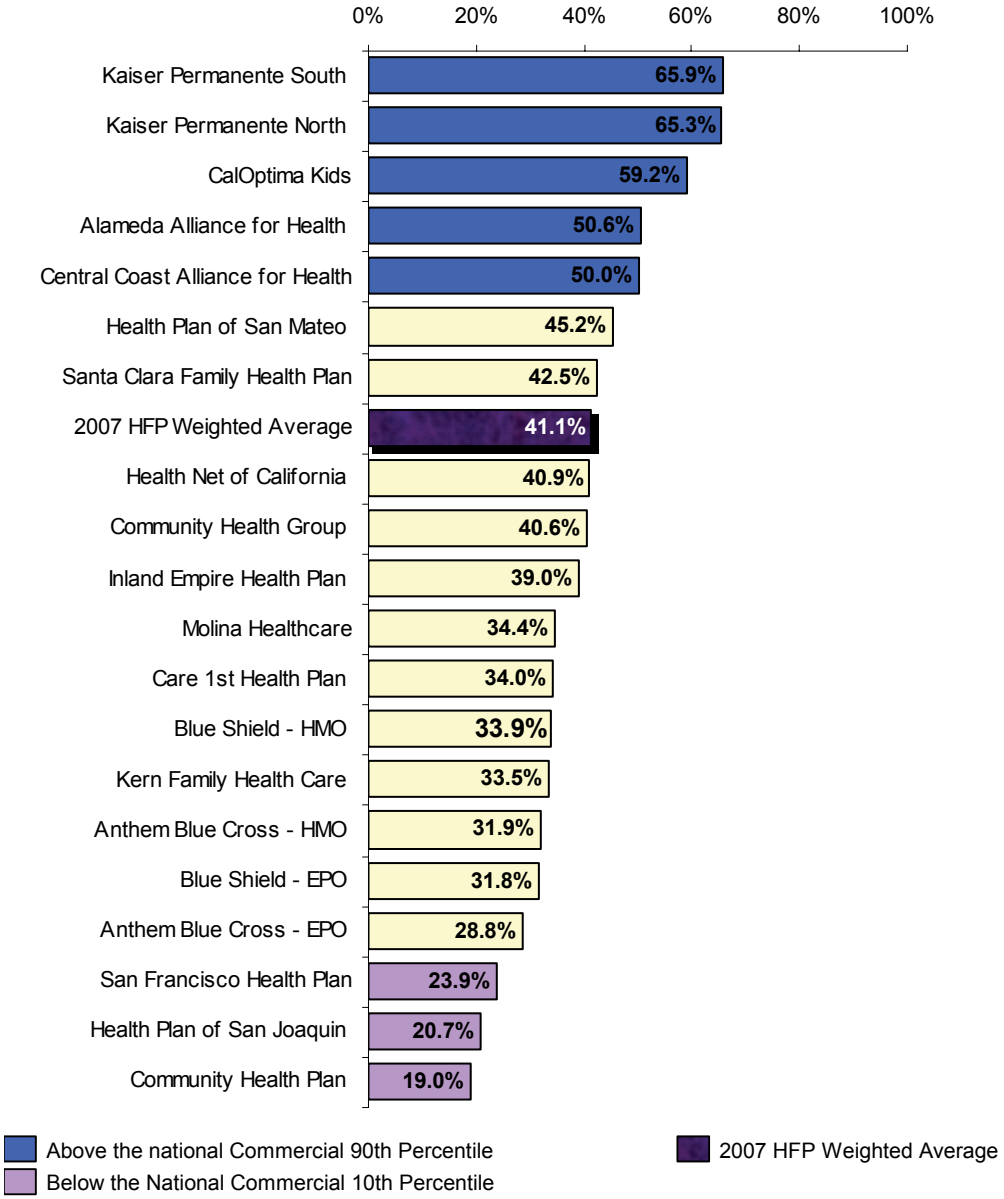
* Rate obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*

** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Chlamydia Screening

The rates below represent the percentage of women ages 16 to 18 years who were identified as sexually active and who had at least one test for Chlamydia.

Figure 95. Individual Plan Rates for Chlamydia Screening



Health Plan Comparison

Individual plan rates varied considerably with rates ranging from 65.9% to 19%.

Five health plans had a rate that was above the national Commercial 90th percentile (48.5%):

- Kaiser Permanente South
- Kaiser Permanente North
- CalOptima Kids
- Alameda Alliance for Health
- Central Coast Alliance for Health

Three health plans had a rate that was below the national Commercial 10th percentile (25.5%):

- San Francisco Health Plan
- Health Plan of San Joaquin
- Community Health Plan

The following plans had an eligible population of less than 30 and were not included in the analysis:

- Contra Costa Health Plan
- CenCal Health
- L.A. Care Health Plan
- Ventura County Health Plan

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx

Figure 96. Chlamydia Screening by Spoken Language

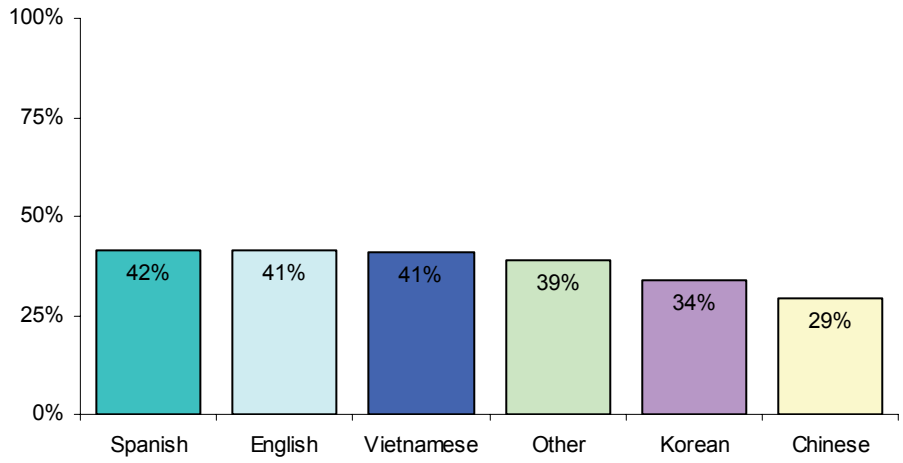
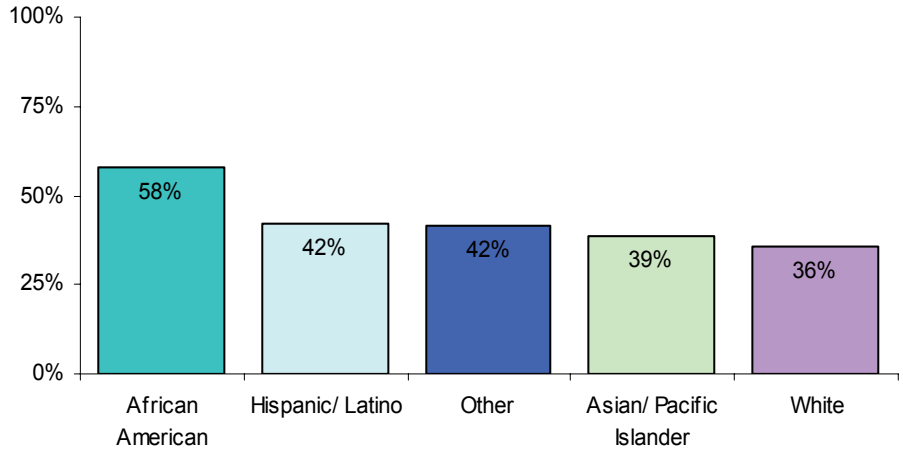


Figure 97. Chlamydia Screening by Ethnicity



Key Findings About Demographics

- Chinese speakers received Chlamydia Screenings at a significantly lower rate compared to Spanish, English and Vietnamese speakers.
- African American Women received Chlamydia Screenings at a significantly higher rate than all other ethnic groups.

Figure 98. Chlamydia Screening by Region

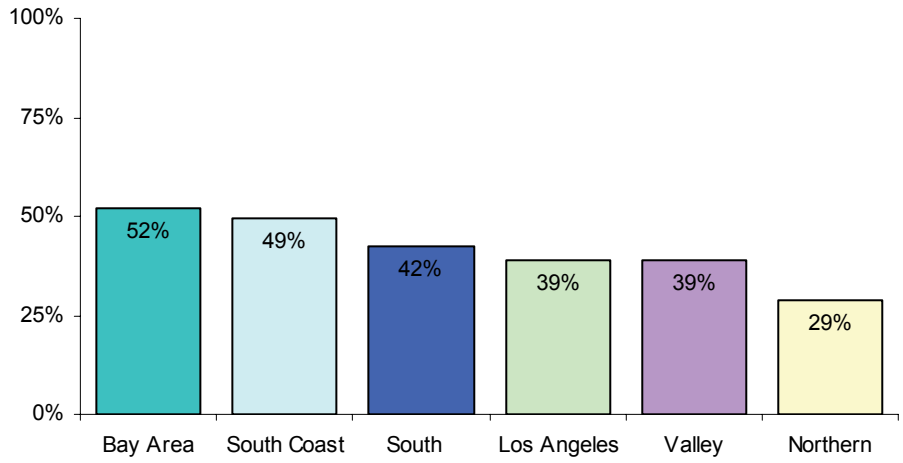


Figure 99. Chlamydia Screening by FPL

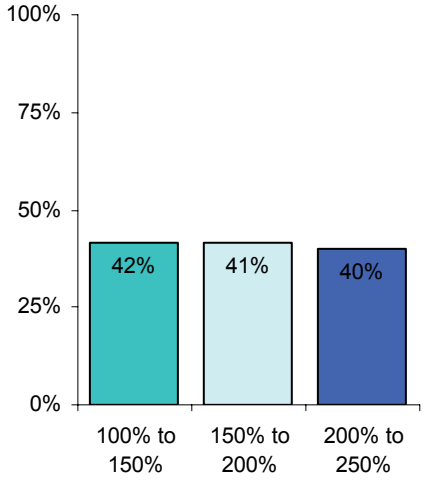
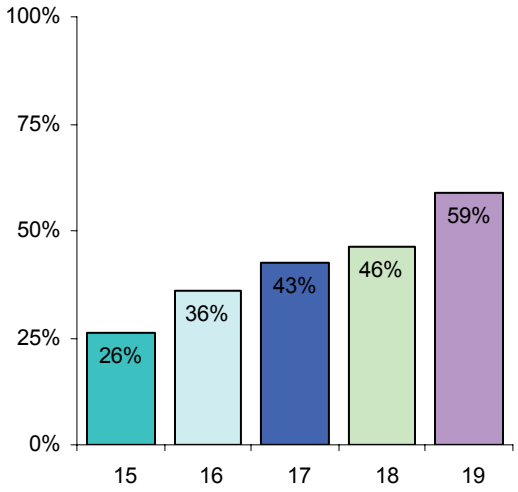


Figure 100. Chlamydia Screening by Age



Key Findings About Demographics

- Young women in the Bay Area and South Coast regions were more likely to have received Chlamydia Screenings than young women in the other regions.
- In the Northern region, less than one in three women were screened for Chlamydia.
- There was no significant difference in the rate for Chlamydia Screening by FPL.
- Rates for Chlamydia Screening increased significantly as age increased, probably due to increased sexual activity.

Mental Health Utilization

Measure Definition

The ***Mental Health Utilization*** measure assesses the number of children and adolescents who received one of the following mental health services:

- Inpatient treatment
- Intensive outpatient and partial hospitalization
- Outpatient or emergency department treatment

Why Is This Important?

According to the National Institute of Mental Health (NIMH), an estimated 1 in 10 children suffer from some form of mental illness and less than 1 in 5 receive treatment.

Results

Two percent (2%) of HFP members received 16,274 mental health services in 2007, an increase from the 15,522 services provided in 2006. This rate is well below both the national Medicaid and Commercial averages.

The majority (87%) of the services were for outpatient or emergency department treatment. Ten percent (10%) were for inpatient treatment and less than 3% were for intensive outpatient or partial hospitalization.

Children enrolled in HFP receive basic mental health services through the health plans. This currently includes 20 outpatient visits and 30 inpatient mental health days per benefit year. Children with a Serious Emotional Disturbance (SED) condition are referred to the county mental health department for treatment of the SED condition. Therefore, any services provided by the county mental health departments for treatment of SED conditions are not included in the results for the *Mental Health Utilization* measure.

Benchmarking and Trend Analysis

Comparisons to national benchmarks are presented in Figure 101 . Comparison of the number of mental health services provided in 2006 and 2007 are presented in Figure 102.

Figure 101. Comparison to National Benchmarks for Mental Health Utilization

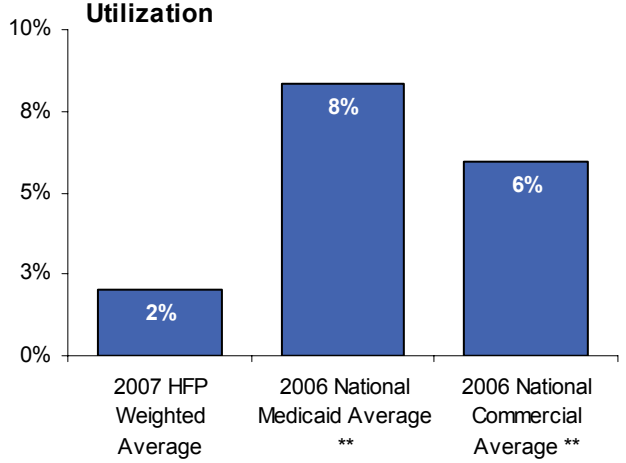
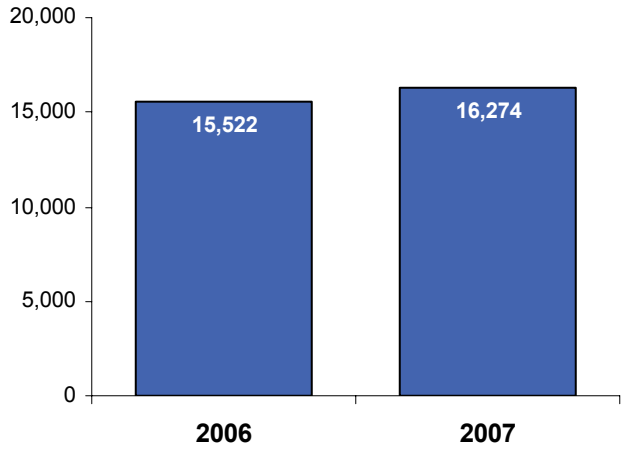


Figure 102. 2 Year Trend for Mental Health Utilization



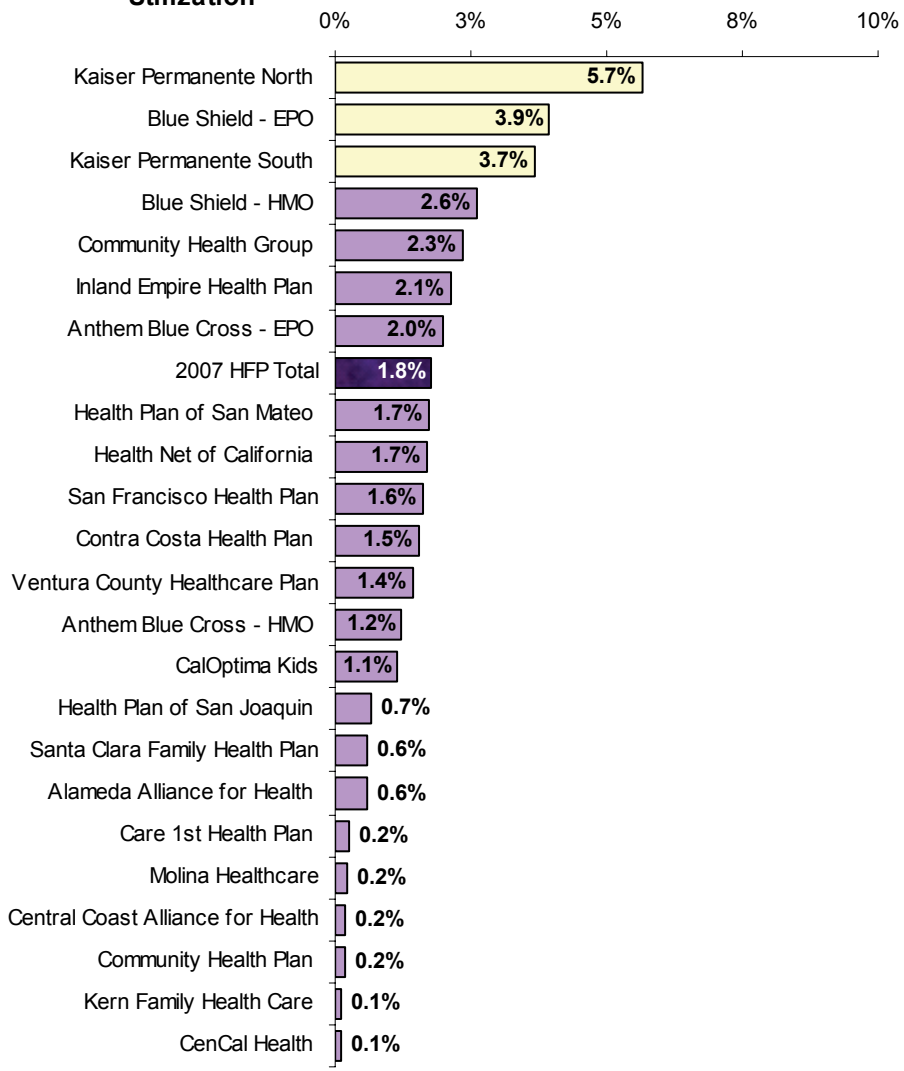
17 National Institute of Mental Health. Treatment of Children with Mental Disorders. http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-disorders/summary.shtml

** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx Rate is based on the mean for children ages 5 to 17 years old.

Mental Health Utilization

The rates below represent the percentage of members within each health plan that received a mental health service.

Figure 103. Individual Plan Rates for Mental Health Utilization



Health Plan Comparison

Individual plan rates varied considerably with rates ranging from 5.7% to significantly less than 1%.

There were no health plans that had rates above the national Commercial 90th percentile for children up to age 17 (9%):

All health plans, except Kaiser Permanente North and South and Blue Shield - EPO, had rates that were below the national Commercial 10th percentile (3.5%) for children up to age 17.

Kaiser Permanente North had a significantly higher percentage of members that received mental health services than any other plan.

Anthem Blue Cross - EPO provided the greatest number of mental health services (3,847). However, Anthem Blue Cross - EPO also has the largest HFP population.

L.A Care Health Plan did not provide any mental health services during 2007 and therefore was not included in the analysis.

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx. Rates are based on the mean for children ages 0 to 17 years old.

Figure 104. Mental Health Utilization by Spoken Language

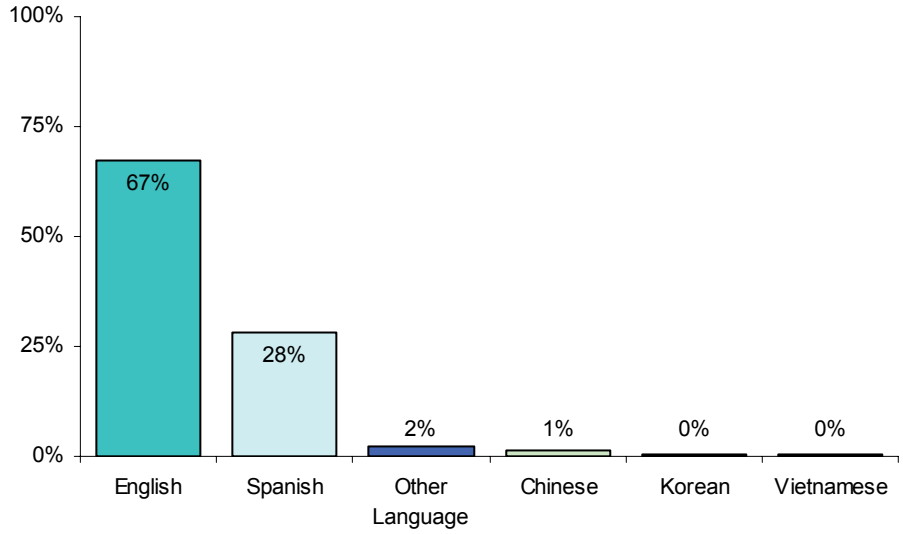
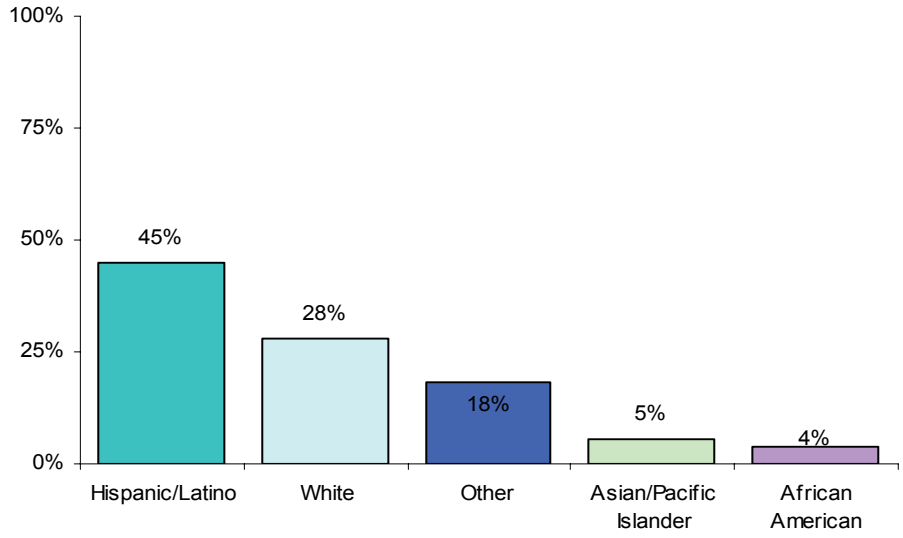


Figure 105. Mental Health Utilization by Ethnicity



Key Findings About Demographics

- English speaking members received 10,964 mental health services, which is a significantly higher rate than other languages.
- Hispanic members received the greatest number of mental health services (7,277), however, they also make up the largest ethnic group in the HFP (55%).
- Virtually no Chinese, Korean or Vietnamese speaking children received mental health services.

Figure 106. Mental Health Utilization by Region

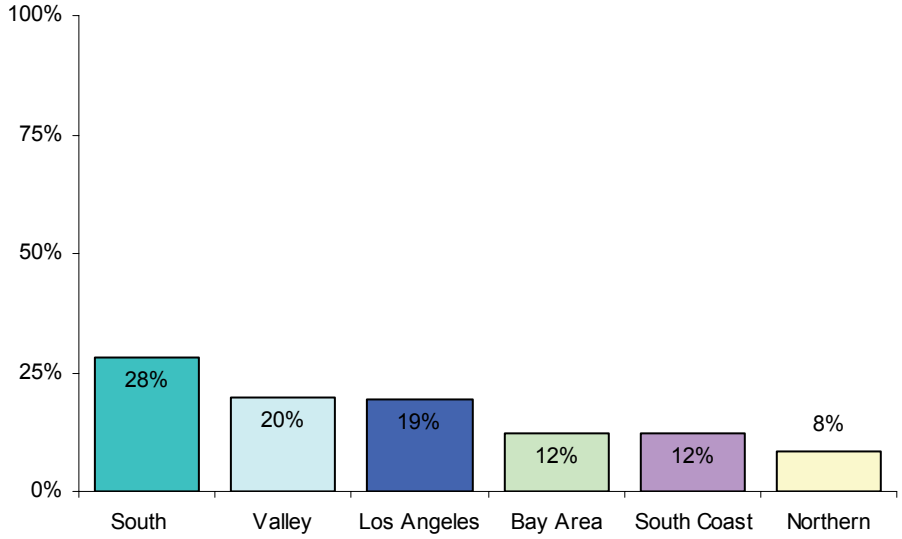


Figure 107. Mental Health Utilization by FPL

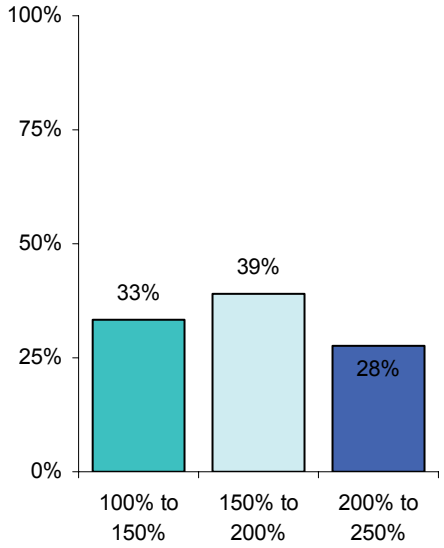
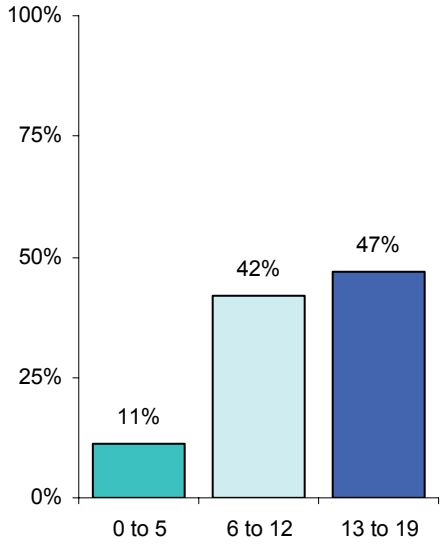


Figure 108. Mental Health Utilization by Age Group



Key Findings About Demographics

- Members in the South region received mental health services at more than twice the rate of those in the Bay Area, South Coast and Northern regions.
- Children in families who had the highest household income were less likely to receive mental health services.
- The greatest number of mental health services were received by children over the age of 13.

Identification of Alcohol and Other Drug Services

Measure Definition

The ***Identification of Alcohol and Other Drug Services*** measure assesses the number of children and adolescents who received one of the following chemical dependency services:

- Inpatient treatment
- Intensive outpatient or partial hospitalization
- Outpatient or emergency department treatment

Why Is This Important?

"There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance use and abuse places a huge burden on the health care system." [18]

Results

Less than one-quarter of 1% (.21%) of HFP children received chemical dependency treatment services, which accounted for 1,758 services. This is far below both the national Medicaid and Commercial averages. However, the number of chemical dependency services provided by HFP plans has increased over the last 3 years.

Benchmarking and Trend Analysis

Comparisons to national benchmarks are presented in Figure 109 . Comparison of the number of alcohol or other drug services provided in 2005 through 2007 are presented in Figure 110.

Figure 109. Comparison to National Benchmarks for Identification of Alcohol and Other Drug Services

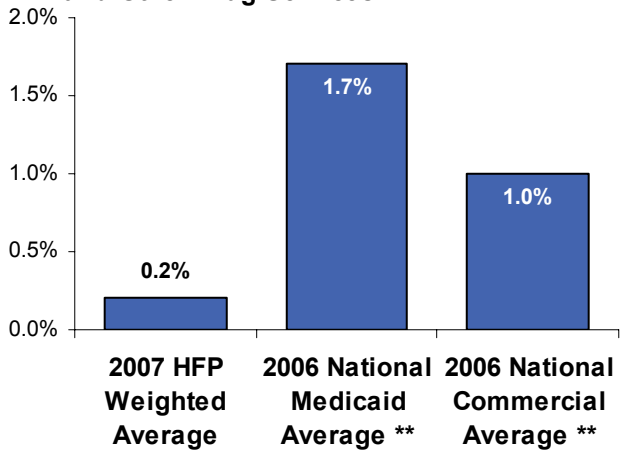
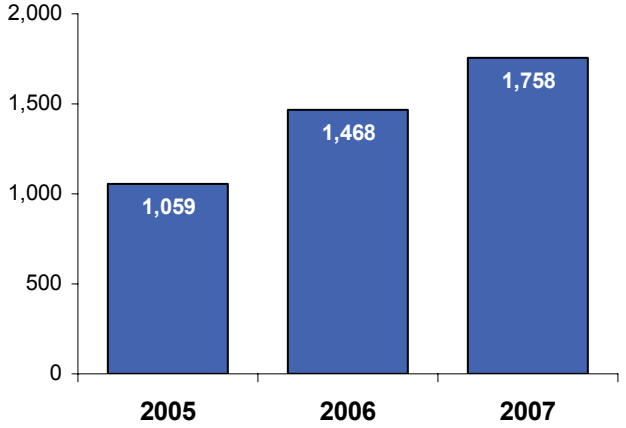


Figure 110. 3 Year Trend for Identification of Alcohol and Other Drug Services

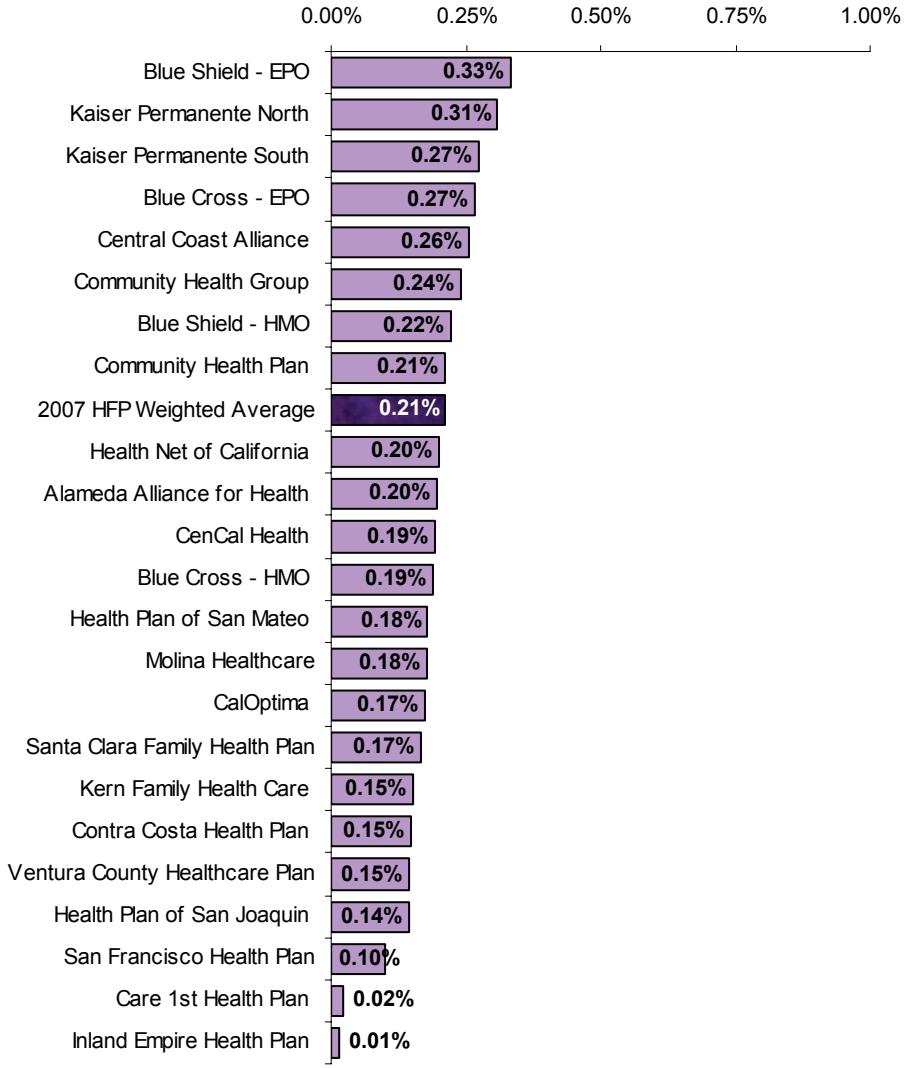


** Rate obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx. Rate is based on the average for children ages 13 to 17 years old.

Identification of Alcohol and Other Drug Services

The rates below represent the percentage of children and adolescents who received one or more chemical dependency treatment services.

Figure 111. Individual Plan Rates for Identification of Alcohol or Other Drug Services



Health Plan Comparison

All health plan rates and the HFP weighted average were below the national Commercial 10th percentile (0.4%).

Note: National Commercial 90th and 10th percentiles obtained from NCQA's website at http://ncqa.org/tabid/334/Default.aspx. Rates are based on the mean for children ages 13 to 17 years old due to the low number of children under age 13 that received services.

Figure 112. Identification of Alcohol or Other Drug Services by Spoken Language

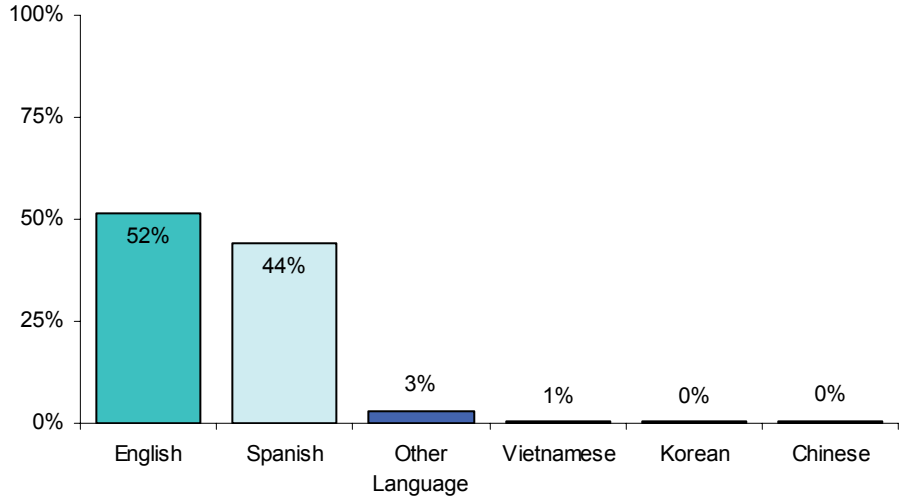
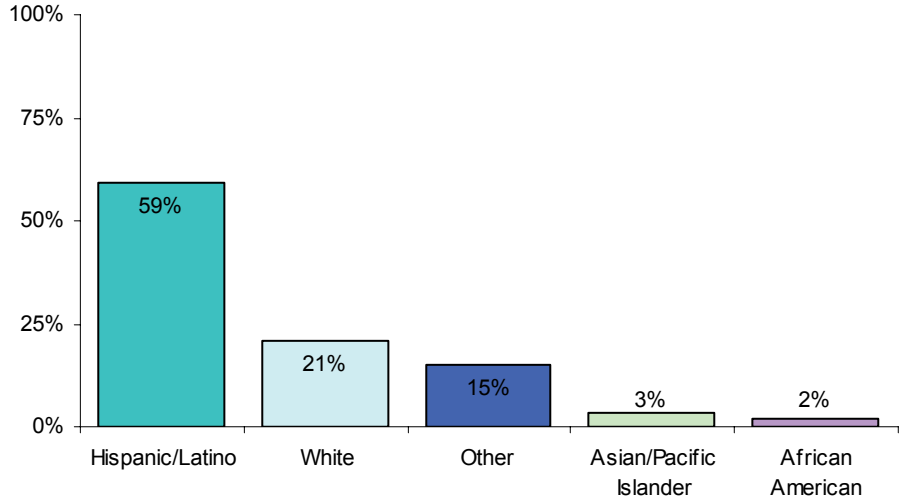


Figure 113. Identification of Alcohol or Other Drug Services by Ethnicity



Key Findings About Demographics

- English and Spanish speaking members received chemical dependency treatment services at a significantly higher rate than members who spoke other languages. English and Spanish speakers account for the largest HFP populations (10% and 55% respectively).
- Virtually no Chinese, Korean or Vietnamese speaking children received chemical dependency treatment services.
- Hispanic members received the greatest number of chemical dependency treatment services, however, they also make up for the largest ethnic groups in the HFP.

Figure 114. Indentification of Alcohol or Other Drug Services by Region

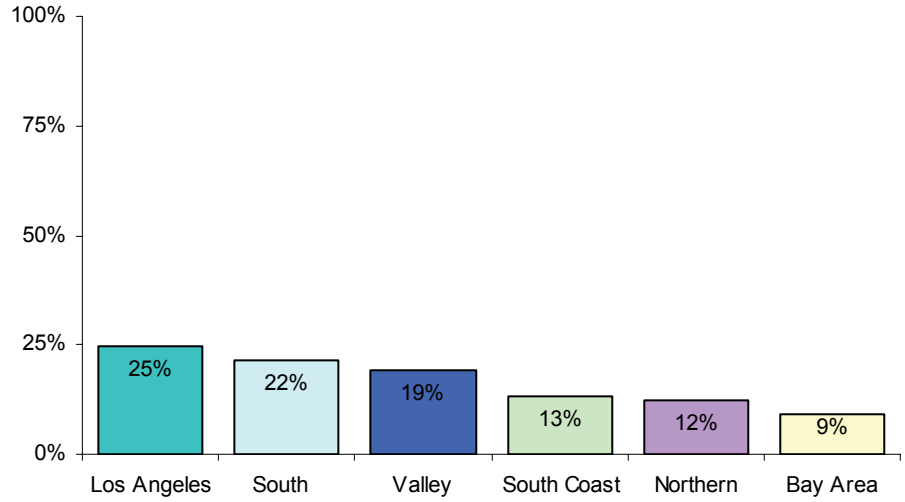


Figure 115. Identification of Alcohol or Other Drug Services by FPL

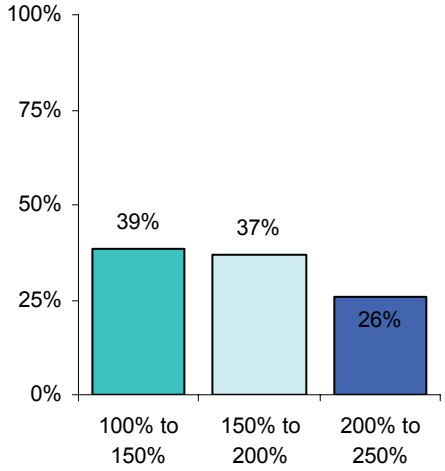
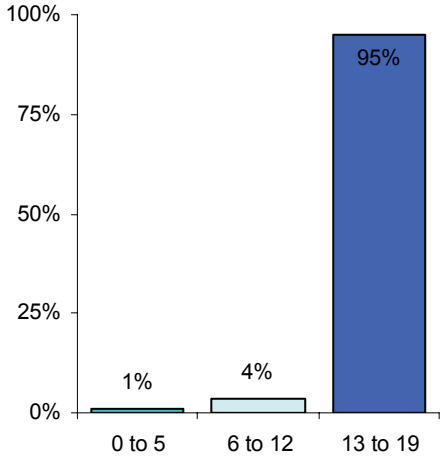


Figure 116. Identification of Alcohol or Other Drug Services by Age Group



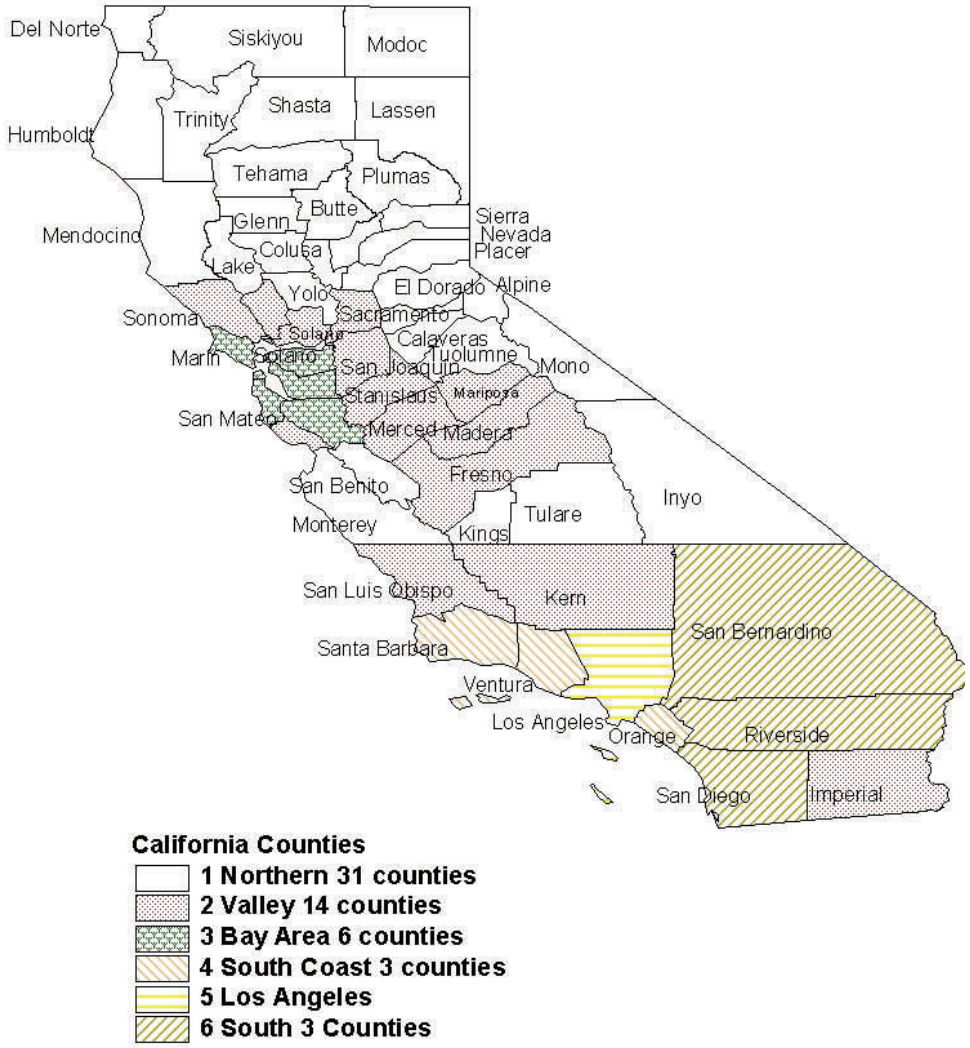
Key Findings About Demographics

- Members in Los Angeles and the South and Valley regions received chemical dependency treatment services at nearly twice the rate of those in the other regions.
- Children in families with the highest household income were less likely to receive chemical dependency treatment services.
- The overwhelming majority of chemical dependency treatment services were received by children over the age of 13.

Appendices

Appendix A. Map of California Regions

California Regions



Listed below are the counties that belong to each of the six regions with HFP enrollment as of December 2007 and the percentage of the total HFP enrollment within each region.

Region	Counties	Total Enrollment for 2007	Percentage of Total Enrollment
Northern	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba	80,419	9.3%
Valley	Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus,	153,947	17.8%
Bay Area	Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara	82,130	9.5%
South Coast	Orange, Santa Barbara, Ventura	110,407	12.7%
Los Angeles	Los Angeles	226,178	26.1%
South	Riverside, San Bernardino, San Diego	212,950	24.6%

Appendix B. Demographics of HFP Member By HEDIS Measure

The tables on the following pages identify the number and percentage of eligible members within each demographic subgroup who received services for each of the HEDIS measures. The Demographic variables include spoken language, ethnicity, region, gender, age group and income groups (identified by FPL).

Measure: Childhood Immunization Status - Combination 2	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	161	177	91.0%
English	2,868	3,583	80.0%
Korean	47	57	82.5%
Other	260	307	84.7%
Spanish	2,319	2,709	85.6%
Vietnamese	181	216	83.8%
Ethnicity			
African American	107	125	85.6%
Asian/ Pacific Islander	590	695	84.9%
Hispanic/ Latino	2,678	3,164	84.6%
Other	2,008	2,446	82.1%
White	453	619	73.2%
Region			
Bay Area	1,047	1,205	86.9%
Los Angeles	1,086	1,348	80.6%
Northern	252	352	71.6%
South	1,720	2,088	82.4%
South Coast	659	783	84.2%
Valley	1,062	1,260	84.3%
Gender			
Female	2,850	3,408	83.6%
Male	2,986	3,641	82.0%
Federal Poverty Level Category			
100% to 150%	732	897	81.6%
150% to 200%	2,189	2,632	83.2%
200% to 250%	2,915	3,520	82.8%

Measure: Childhood Immunization Status - Combination 3	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	153	177	86.4%
English	2,694	3,583	75.2%
Korean	45	57	78.9%
Other	244	307	79.5%
Spanish	2,171	2,708	80.2%
Vietnamese	160	216	74.1%
Ethnicity			
African American	104	125	83.2%
Asian/ Pacific Islander	546	695	78.6%
Hispanic/ Latino	2,505	3,163	79.2%
Other	1,890	2,446	77.3%
White	422	619	68.2%
Region			
Bay Area	1,004	1,204	83.4%
Los Angeles	1,002	1,348	74.3%
Northern	230	352	65.3%
South	1,607	2,088	77.0%
South Coast	609	783	77.8%
Valley	1,007	1,260	79.9%
Gender			
Female	2,674	3,408	78.5%
Male	2,793	3,640	76.7%
Federal Poverty Level Category			
100% to 150%	689	897	76.8%
150% to 200%	2,043	2,632	77.6%
200% to 250%	2,735	3,519	77.7%

Appendix B. Demographics of HFP Member By HEDIS Measure

Measure: Well-Child Visits in the First 15 Months of Life - 6 or More Visits	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	70	104	67.3%
English	1,250	2,362	52.9%
Korean	37	63	58.7%
Other	263	428	61.4%
Spanish	780	1,511	51.6%
Vietnamese	109	175	62.3%
Ethnicity			
African American	21	51	41.2%
Asian/Pacific Islander	255	415	61.4%
Hispanic/Latino	624	1,298	48.1%
Other	1,414	2,534	55.8%
White	195	345	56.5%
Region			
Bay Area	409	652	62.7%
Los Angeles	365	944	38.7%
Northern	205	314	65.3%
South	678	1,324	51.2%
South Coast	366	618	59.2%
Valley	485	787	61.6%
Gender			
Female	1,182	2,258	52.3%
Male	1,327	2,375	55.9%
Federal Poverty Level Category			
100% to 150%	222	417	53.2%
150% to 200%	640	1,179	54.3%
200% to 250%	1647	3047	54.1%

Measure: Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	523	641	81.6%
English	8,378	12,942	64.7%
Korean	82	118	69.5%
Other	551	873	63.1%
Spanish	8,325	11,357	73.3%
Vietnamese	287	394	72.8%
Ethnicity			
African American	562	865	65.0%
Asian/ Pacific Islander	1,926	2,688	71.7%
Hispanic/ Latino	10,493	14,841	70.7%
Other	3,590	5,290	67.9%
White	1,575	2,641	59.6%
Region			
Bay Area	3,950	5,380	73.4%
Los Angeles	4,419	6,450	68.5%
Northern	584	885	66.0%
South	3,558	5,359	66.4%
South Coast	1,647	2,330	70.7%
Valley	3,983	5,914	67.3%
Gender			
Female	8,807	12,735	69.2%
Male	9,339	13,590	68.7%
Age			
3 years	4,123	5,756	71.6%
4 years	4,816	6,476	74.4%
5 years	5,168	6,722	76.9%
6 years	3,515	6,705	52.4%
Federal Poverty Level Category			
100% to 150%	3,186	4,699	67.8%
150% to 200%	8,707	12,453	69.9%
200% to 250%	6,253	9,173	68.2%

Appendix B. Demographics of HFP Member By HEDIS Measure

Measure: Adolescent Well-Care Visits	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	676	1,336	50.6%
English	7,238	21,099	34.3%
Korean	90	267	33.7%
Other	631	1,851	34.1%
Spanish	8,558	21,071	40.6%
Vietnamese	230	466	49.4%
Ethnicity			
African American	793	2,177	36.4%
Asian/ Pacific Islander	1,912	4,723	40.5%
Hispanic/ Latino	10,310	26,073	39.5%
Other	2,819	7,860	35.9%
White	1,589	5,257	30.2%
Region			
Bay Area	3,450	8,035	42.9%
Los Angeles	5,571	13,601	41.0%
Northern	301	1,112	27.1%
South	3,082	9,227	33.4%
South Coast	1,844	4,581	40.3%
Valley	3,170	9,517	33.3%
Gender			
Female	8,820	22,276	39.6%
Male	8,603	23,814	36.1%
Age			
12 years	2,731	7,063	38.7%
13 years	2,538	6,975	36.4%
14 years	2,959	6,800	43.5%
15 years	2,818	6,745	41.8%
16 years	2,485	6,551	37.9%
17 years	2,122	6,103	34.8%
18 years	1,382	4,869	28.4%
19 years	93	374	24.9%
Federal Poverty Level Category			
100% to 150%	6,087	16,043	37.9%
150% to 200%	6,869	18,313	37.5%
200% to 250%	4,467	11,734	38.1%

Measure: Children and Adolescents Access to PCP, Ages 12 - 24 Months	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	359	371	96.8%
English	7,597	7,819	97.2%
Korean	249	251	99.2%
Other	1,772	1,824	97.1%
Spanish	4,667	4,803	97.2%
Vietnamese	399	407	98.0%
Ethnicity			
African American	175	177	98.9%
Asian/ Pacific Islander	1,219	1,242	98.1%
Hispanic/ Latino	4,462	4,602	97.0%
Other	7,960	8,188	97.2%
White	1,227	1,266	96.9%
Region			
Bay Area	1,523	1,541	98.8%
Los Angeles	3,572	3,699	96.6%
Northern	1,697	1,722	98.5%
South	3,572	3,675	97.2%
South Coast	2,069	2,114	97.9%
Valley	2,591	2,704	95.8%
Gender			
Male	7,869	8,066	97.6%
Female	7,174	7,409	96.8%
Federal Poverty Level Category			
100% to 150%	1,109	1,146	96.8%
150% to 200%	3,554	3,648	97.4%
200% to 250%	10,380	10,681	97.2%

Appendix B. Demographics of HFP Member By HEDIS Measure

Measure: Children and Adolescents Access to PCP, Ages 25 Months - 6 Years	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	3,522	3,805	92.6%
English	56,882	63,777	89.2%
Korean	1,828	2,005	91.2%
Other	4,515	5,073	89.0%
Spanish	57,588	64,416	89.4%
Vietnamese	3,614	3,957	91.3%
Ethnicity			
African American	2,123	2,435	87.2%
Asian/ Pacific Islander	14,786	16,274	90.9%
Hispanic/ Latino	71,611	80,290	89.2%
Other	26,139	28,959	90.3%
White	13,290	15,075	88.2%
Region			
Bay Area	13,553	14,793	91.6%
Los Angeles	29,664	34,291	86.5%
Northern	12,892	13,926	92.6%
South	30,758	34,961	88.0%
South Coast	17,919	19,419	92.3%
Valley	23,097	25,573	90.3%
Gender			
Female	61,952	69,293	89.4%
Male	65,997	73,740	89.5%
Federal Poverty Level Category			
100% to 150%	22,127	25,072	88.3%
150% to 200%	59,263	66,419	89.2%
200% to 250%	46,559	51,542	90.3%

Measure: Children and Adolescents Access to PCP, Ages 7 - 11 Years	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	4,887	5,421	90.1%
English	49,655	55,677	89.2%
Korean	1,651	1,964	84.1%
Other	3,885	4,450	87.3%
Spanish	59,362	66,938	88.7%
Vietnamese	2,792	3,173	88.0%
Ethnicity			
African American	2,303	2,622	87.8%
Asian/ Pacific Islander	15,724	17,863	88.0%
Hispanic/ Latino	74,383	83,707	88.9%
Other	16,317	18,274	89.3%
White	13,505	15,157	89.1%
Region			
Bay Area	12,924	14,094	91.7%
Los Angeles	31,977	36,902	86.7%
Northern	11,544	12,665	91.1%
South	28,479	32,645	87.2%
South Coast	15,808	17,302	91.4%
Valley	21,445	23,954	89.5%
Gender			
Female	59,133	66,782	88.5%
Male	63,099	70,841	89.1%
Federal Poverty Level Category			
100% to 150%	36,539	41,570	87.9%
150% to 200%	51,683	58,125	88.9%
200% to 250%	36,050	40,211	89.7%

Appendix B. Demographics of HFP Member By HEDIS Measure

Measure: Children and Adolescents Access to PCP, Ages 12 - 18 Years	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	8,404	9,822	85.6%
English	62,663	72,217	86.8%
Korean	2,655	3,277	81.0%
Other	5,195	6,312	82.3%
Spanish	80,513	94,805	84.9%
Vietnamese	3,093	3,657	84.6%
Ethnicity			
African American	3,493	4,168	83.8%
Asian/ Pacific Islander	21,633	25,739	84.0%
Hispanic/ Latino	96,650	113,173	85.4%
Other	21,289	24,849	85.7%
White	19,458	22,161	87.8%
Region			
Bay Area	16,135	18,098	89.2%
Los Angeles	45,674	55,461	82.4%
Northern	15,331	17,341	88.4%
South	37,475	44,475	84.3%
South Coast	20,068	22,553	89.0%
Valley	27,791	32,103	86.6%
Gender			
Female	79,096	91,837	86.1%
Male	83,427	98,253	84.9%
Federal Poverty Level Category			
100% to 150%	56,840	66,848	85.0%
150% to 200%	64,184	75,263	85.3%
200% to 250%	41,499	47,979	86.5%

Measure: Use of Appropriate Medications for People with Asthma	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	144	148	97.3%
English	3,311	3,535	93.7%
Other	161	171	94.2%
Spanish	2,723	2,896	94.0%
Vietnamese	132	136	97.1%
Ethnicity			
African American	237	254	93.3%
Asian/ Pacific Islander	641	668	96.0%
Hispanic/ Latino	3,712	3,944	94.1%
Other	978	1,050	93.1%
White	927	995	93.2%
Region			
Bay Area	667	702	95.0%
Los Angeles	1,440	1,565	92.0%
Northern	780	829	94.1%
South	1,378	1,478	93.2%
South Coast	805	853	94.4%
Valley	1,425	1,484	96.0%
Gender			
Female	2,351	2,497	94.2%
Male	4,144	4,414	93.9%
Age Group			
5 to 9 Years	2,950	3,076	95.9%
10 to 17 Years	3,346	3,601	92.9%
18 Years	199	234	85.0%
Federal Poverty Level Category			
100% to 150%	1,830	1,952	93.8%
150% to 200%	2,703	2,879	93.9%
200% to 250%	1,962	2,080	94.3%

Appendix B. Demographics of HFP Member By HEDIS Measure

Measure: Use of Appropriate Medications for Children with Upper Respiratory Infections	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	719	3,223	77.7%
English	4,274	27,565	84.5%
Korean	127	1,182	89.3%
Other	398	2,570	84.5%
Spanish	5,594	31,210	82.1%
Vietnamese	418	2,212	81.1%
Ethnicity			
African American	107	1,036	89.7%
Asian/Pacific Islander	1,758	9,775	82.0%
Hispanic/ Latino	6,754	38,138	82.3%
Other	1,911	12,268	84.4%
White	1,000	6,745	85.2%
Region			
Bay Area	504	6,718	92.5%
Los Angeles	3,792	18,990	80.0%
Northern	995	6,451	84.6%
South	2,350	14,118	83.4%
South Coast	2,007	10,272	80.5%
Valley	1,864	11,292	83.5%
Gender			
Female	5,620	33,904	83.4%
Male	5,910	34,868	83.1%
Age Group			
0 to 5	4,481	30,749	85.4%
6 to 12	2,344	10,849	78.4%
13 to 19	4,705	26,364	82.2%
Federal Poverty Level Category			
100% to 150%	3,274	17,880	81.7%
150% to 200%	4,764	27,868	82.9%
200% to 250%	3,492	22,214	84.3%

Measure: Appropriate Testing for Children with Pharyngitis	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	73	993	7.4%
English	5,316	13,670	38.9%
Korean	36	254	14.2%
Other	354	1,062	33.3%
Spanish	4,472	16,319	27.4%
Vietnamese	52	448	11.6%
Ethnicity			
African American	240	494	48.6%
Asian/ Pacific Islander	533	2,911	18.3%
Hispanic /Latino	5,872	20,337	28.9%
Other	1,694	4,878	34.7%
White	1,964	4,126	47.6%
Region			
Bay Area	902	1,946	46.4%
Valley	2,305	5,673	40.6%
Northern	1,410	3,790	37.2%
South	2,453	7,886	31.1%
South Coast	1,084	4,130	26.2%
Los Angeles	2,133	9,272	23.0%
Gender			
Female	5,368	16,856	31.8%
Male	5,094	16,314	31.2%
Age Group			
2 to 5	1,936	8,109	23.9%
6 to 12	2,780	8,058	34.5%
13 to 19	5,587	16,579	33.7%
Federal Poverty Level Category			
100% to 150%	2,942	9,964	29.5%
150% to 200%	4,196	13,254	31.7%
200% to 250%	3,165	9,528	33.2%

Appendix B. Demographics of HFP Member By HEDIS Measure

Measure: Chlamydia Screening	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	63	216	29.2%
English	2,224	5,387	41.3%
Korean	20	59	33.9%
Other	117	300	39.0%
Spanish	2,012	4,839	41.6%
Vietnamese	44	108	40.7%
Ethnicity			
African American	215	371	58.0%
Asian/ Pacific Islander	276	711	38.8%
Hispanic/ Latino	2,542	6,067	41.9%
Other	697	1,667	41.8%
White	750	2,093	35.8%
Region			
Bay Area	482	923	52.2%
Los Angeles	1,063	2,730	38.9%
Northern	359	1,255	28.6%
South	1,049	2,484	42.2%
South Coast	742	1,503	49.4%
Valley	782	2,010	38.9%
Age			
15	145	551	26.3%
16	1,129	3,129	36.1%
17	1,516	3,560	42.6%
18	1,354	2,915	46.4%
19	130	220	59.1%
Federal Poverty Level Category			
100% to 150%	1,678	4,043	41.5%
150% to 200%	1,736	4,186	41.5%
200% to 250%	1,066	2,680	39.8%

Measure: Mental Health Utilization	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	232	16,274	1.4%
English	10,964	16,274	67.4%
Korean	77	16,274	0.5%
Other Language	386	16,274	2.4%
Spanish	4,550	16,274	28.0%
Vietnamese	65	16,274	0.4%
Ethnicity			
African American	610	16,274	3.7%
Asian/Pacific Islander	872	16,274	5.4%
Hispanic/Latino	7,277	16,274	44.7%
Other	2,977	16,274	18.3%
White	4,538	16,274	27.9%
Region			
Bay Area	1,996	16,274	12.3%
Los Angeles	3,117	16,274	19.2%
Northern	1,374	16,274	8.4%
South	4,555	16,274	28.0%
South Coast	1,998	16,274	12.3%
Valley	3,214	16,274	19.7%
Gender			
Female	6,787	16,274	41.7%
Male	9,487	16,274	58.3%
Age Group			
0 to 5	1,829	16,274	11.2%
6 to 12	6,814	16,274	41.9%
13 to 19	7,631	16,274	46.9%
Federal Poverty Level Category			
100% to 150%	5,442	16,274	33.4%
150% to 200%	6,317	16,274	38.8%
200% to 250%	4,515	16,274	27.7%

Appendix B. Demographics of HFP Member By HEDIS Measure

Measure: Identification of Alcohol and Other Drug Services	Number of Members Who Received Service	Number of Members in the Measure	Percentage Who Received Service Within Subgroup
Spoken Language			
Chinese	6	1,758	0.3%
English	907	1,758	51.6%
Korean	7	1,758	0.4%
Other Language	52	1,758	3.0%
Spanish	777	1,758	44.2%
Vietnamese	9	1,758	0.5%
Ethnicity			
African American	30	1,758	1.7%
Asian/Pacific Islander	59	1,758	3.4%
Hispanic/Latino	1,037	1,758	59.0%
Other	268	1,758	15.2%
White	364	1,758	20.7%
Region			
Bay Area	161	1,758	9.2%
Los Angeles	431	1,758	24.5%
Northern	217	1,758	12.3%
South	379	1,758	21.6%
South Coast	235	1,758	13.4%
Valley	334	1,758	19.0%
Gender			
Female	706	1,758	40.2%
Male	1,076	1,758	61.2%
Age Group			
0 to 5	22	1,758	1.3%
6 to 12	65	1,758	3.7%
13 to 19	1,671	1,758	95.1%
Federal Poverty Level Category			
100% to 150%	678	1,758	38.6%
150% to 200%	649	1,758	36.9%
200% to 250%	455	1,758	25.9%

Appendix C. Health Plan Performance on HEDIS Measures

Health Plan	Total ▲	Total ▼	CIS2	CIS3	W15	W34	AWC	CAP1	CAP2	CAP3	CAP4	ASM	URI	CWP	CHL
Alameda Alliance for Health	7	1	▲	▲		▲		▲				▲	▲	▼	▲
Anthem Blue Cross - EPO	2	3	▼	▼				▲				▲		▼	
Anthem Blue Cross - HMO		1												▼	
Blue Shield - EPO		3		▼	▼									▼	
Blue Shield - HMO		5			▼			▼		▼	▼			▼	
CalOptima Kids	4	1				▲	▲					▲		▼	▲
Care 1st Health Plan		7						▼	▼	▼	▼	▼	▼	▼	
CenCal Health	1	2		▲				▼						▼	
Central Coast Alliance for Health	2	1						▲						▼	▲
Community Health Group		6			▼			▼	▼	▼	▼			▼	
Community Health Plan		7			▼				▼	▼	▼	▼		▼	▼
Contra Costa Health Plan	1	2		▲	▼									▼	
Health Net of California	1	2		▲				▼						▼	
Health Plan of San Joaquin	4	7	▲	▲			▲	▼	▼	▼	▼	▲	▼	▼	▼
Health Plan of San Mateo	1	1						▲						▼	
Inland Empire Health Plan		2			▼									▼	
Kaiser Permanente North	6			▲				▲				▲	▲	▲	▲
Kaiser Permanente South	3	1			▼			▲					▲		▲
Kern Family Health Care	2	1	▲	▲										▼	
LA Care Health Plan		4						▼	▼		▼			▼	
Molina Healthcare		2										▼		▼	
San Francisco Health Plan	4	2	▲	▲		▲	▲							▼	▼
Santa Clara Family Health Plan	1	1						▲						▼	
Ventura County Healthcare Plan	1	1						▲						▼	

CIS2 = Childhood Immunization Status - Combination 2
CIS3 = Childhood Immunization Status - Combination 3
W15 = Well-Child Visits in the First 15 Months of Life
W34 = Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life
AWC = Adolescent Well-Care Visits
CAP1 = Children and Adolescents Access to PCP, Ages 12 - 24 Months
CAP2 = Children and Adolescents Access to PCP, Ages 25 Months - 6 Years
CAP3 = Children and Adolescents Access to PCP, Ages 7 - 11 Years
CAP4 = Children and Adolescents Access to PCP, Ages 12 - 18 Years
ASM = Use of Appropriate Medications for People with Asthma
URI = Use of Appropriate Medications for Children with Upper Respiratory Infections
CWP = Appropriate Testing for Children with Pharyngitis
CHL = Chlamydia Screening

Note: The Mental Health Utilization and Identification of Alcohol and Other Drug Services measures were not included in this analysis because no plans had scores above the national Commercial 90th percentile and most, if not all plans, were below the national Commercial 10th percentile.